Health History Questionnaire

Energetic Health Acupuncture & Oriental Medicine
230 N. 1680 E., Ste E2 ~ St. George, UT 84790
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Information for your Acupuncturist

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

I. General Patient Information

Date: ____/____/____ Name: _____

Address:_____ _ _____

City_____State _____ Zip_____

Email_____

Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____

Gender: [ ] M [ ] F Height: ____'____" Weight: _____lbs.

Occupation: _____Employer: _____

How did you hear about our office? _____

Primary Care Physician: _____

Emergency Contact:_____Relationship:_____

Phone:_____Cell/Work Phone:_____

Medications (Prescription & Over-the-counter): _____

_____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Date of onset	
1.	q	q	q	_____	_____
2.	q	q	q	_____	_____
3.	q	q	q	_____	_____
4.	q	q	q	_____	_____
5.	q	q	q	_____	_____
6.	q	q	q	_____	_____
7.	q	q	q	_____	_____

Family History:

Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

	Father	Mother	Brothers	Sisters	Child	Spouse
Health (G=good; P=poor)						
Age, if living						
If deceased, age of death						
Cause of death						
Cancer						
Diabetes						
Heart Disease/ High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hay fever, hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Other:						

Supplements (if any vitamins, herbs, minerals, etc): _____
_____

Allergies:
Are you hypersensitive or allergic to:
Any drugs? q Yes q No Please list:_____
Any foods? q Yes q No Please list:_____

Symptom Profile
For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you've had in the past, noting the date in the space provided.

Skin disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Acne, Boils	q	q	_____
Acute Hair Loss	q	q	_____
Color Change	q	q	_____
Eczema, Hives	q	q	_____
Itching	q	q	_____
Nail Fungus	q	q	_____
Dry Skin	q	q	_____
Rash	q	q	_____
Other_____	q	q	_____

Respiratory System Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Bronchitis	q	q	_____
Chronic Asthma	q	q	_____
Chronic Cough	q	q	_____
Emphysema	q	q	_____

Frequent Colds	q	q	_____
Pain in Breathing	q	q	_____
Pleurisy	q	q	_____
Pneumonia	q	q	_____
Shortness of Breath	q	q	_____
Sinus Congestion	q	q	_____
Spitting up Blood	q	q	_____
Temporary Cough	q	q	_____
Tuberculosis	q	q	_____
Nasal drainage	q	q	_____
Other_____	q	q	_____

Emotional or Mental Illness:

Currently have?	**YES**	**PAST**	**WHEN?**
Anxiety	q	q	_____
Depression	q	q	_____
Considered or Attempted Suicide	q	q	_____
Irritability	q	q	_____
Mood Swings	q	q	_____
Other_____	q	q	_____

Head, Ear, Eyes, Nose, Throat:

Currently have:	**YES**	**PAST**	**WHEN?**
Headaches	q	q	_____
Migraines	q	q	_____
Head Injury	q	q	_____
Hay Fever	q	q	_____
Ears:	**YES**	**PAST**	**WHEN?**
Earaches	q	q	_____
Ringing in Ears	q	q	_____
Impaired Hearing	q	q	_____
Dizziness	q	q	_____
Eyes:			
Cataracts	q	q	_____
Color Blindness	q	q	_____
Contacts or Glasses	q	q	_____
Double Vision	q	q	_____
Eye Pain or Strain	q	q	_____
Glaucoma	q	q	_____
Impaired Vision	q	q	_____
Tearing or Dryness	q	q	_____
Spots in Front of Eyes	q	q	_____
Nose:			
Nose Bleeds	q	q	_____
Loss of Smell	q	q	_____

Mouth:

Bleeding Gums	q	q	_____
Dental Cavities	q	q	_____
Dry Mouth	q	q	_____
Oral Sores	q	q	_____
Oral Thrush	q	q	_____
Teeth Grinding	q	q	_____
Jaw Problems, TMJ	q	q	_____

Throat:

Currently have?	**YES**	**PAST**	**WHEN?**
Goiter	q	q	_____
Hoarseness	q	q	_____
Swollen Glands	q	q	_____
Trouble Swallowing	q	q	_____
Neck Pain/Stiffness	q	q	_____
Frequent Sore Throat	q	q	_____
Other_____	q	q	_____

Digestive Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Nausea	q	q	_____
Vomiting	q	q	_____
Loss of Appetite	q	q	_____
Ulcer	q	q	_____
Heartburn	q	q	_____
Gas or bloating	q	q	_____
Internal Cramping	q	q	_____
Constipation	q	q	_____
Diarrhea	q	q	_____
Loose Stool	q	q	_____
Hemorrhoids	q	q	_____
Bowel Movement Frequency?			_____
Is this a change?			_____
Other_____	q	q	_____

Cardiovascular Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Heart Disease	q	q	_____
Endocarditis	q	q	_____
Chest Pain	q	q	_____
Heart Murmur	q	q	_____
Palpitations or fluttering	q	q	_____
High Blood Pressure	q	q	_____
Low Blood Pressure	q	q	_____
Phlebitis	q	q	_____
Blood Clots	q	q	_____
Ankle Swelling	q	q	_____
Fainting	q	q	_____
Other_____	q	q	_____

Urinary Tract Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Frequent infection	q	q	_____
Frequent Night Urination	q	q	_____
Inability to hold urine	q	q	_____
Burning or pain during urination	q	q	_____
Increased frequency	q	q	_____
Kidney stones	q	q	_____
Other_____	q	q	_____

Musculoskeletal Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Weakness	q	q	_____

Muscle Spasms or cramps q q _____
Joint pain, swelling, or stiffness q q _____
Sciatica q q _____
Fibromyalgia q q _____
Broken bones q q _____
Any other pain q q _____
Location:_____
Other_____ q q _____

Miscellaneous:

Currently have?	**YES**	**PAST**	**WHEN?**
Easy bleeding or bruising	q	q	_____
Varicose veins	q	q	_____
Anemia	q	q	_____
Slow wound healing	q	q	_____
Chronic infections	q	q	_____
Day sweats	q	q	_____
Night sweats	q	q	_____
Cold hands or feet	q	q	_____
Heat or cold intolerance	q	q	_____
Fatigue	q	q	_____
Chronic fatigue syndrome	q	q	_____
Hypoglycemia	q	q	_____
Hyperthyroid	q	q	_____
Excessive Thirst	q	q	_____
Excessive hunger	q	q	_____
Diabetes	q	q	_____
Gallbladder disease	q	q	_____
Liver disease	q	q	_____
Jaundice	q	q	_____
Hepatitis	q	q	_____

Type?_____
Other_____ q q _____

Lifestyle Habits:

Do you…

Exercise? q No qYes
What kind?_____
How often?_____
Take vacations? q No qYes
How often?_____

Tobacco, food and drink habits:

Do you…

Use tobacco q No qYes
How much/how often?_____
Smoked previously? q No qYes
How long?_____
How many packs a day?_____
Ever been treated for drug dependence? q No qYes
Drink Alcohol? q No qYes
How much/often?_____
Drink caffeinated beverages? q No qYes
How much/often?_____

Eat out? q No qYes
Times per week?_____

Sleep habits:

Do you…
Sleep well? q No qYes
Awaken rested q No qYes
Average 6-8 hrs sleep q No qYes
Spend time outside q No qYes
What time of day is your energy at its best?_____
How many meals to you eat per day?_____
Go on diets often? q No qYes

Typical food intake:
Breakfast_____
_____

Lunch_____
_____

Dinner_____
_____

Snacks_____
_____

Which selection most closely describes your diet? (You may check more than one item)
q Vegan q Raw Foods q Vegetarian q Mostly Vegetarian q Low fat q Low carb q Allergy conscious
q Fast food/restaurants q Ethnic q Typical American

Which of these selections do you take daily (3 checks), several times a week (2 checks), once a week (1 check):
Sugar_____ Sugar substitutes_____ Coffee_____ Tobacco_____ Red Meat_____ Alcohol_____ Diet drinks_____

Any history of psychological, physical or sexual abuse? q No qYes
_____

FOR MEN ONLY:

Do you now, or have you ever had…?

Testicular masses	q No	qYes	When?_____
Testicular pain	q No	qYes	When?_____
Prostate Disease	q No	qYes	When?_____
Impotence	q No	qYes	When?_____
Premature ejaculation	q No	qYes	When?_____
Hernias	q No	qYes	When?_____
Condyloma	q No	qYes	When?_____
Syphilis	q No	qYes	When?_____
Genital, oral or rectal herpes	q No	qYes	When?_____
Gonorrhea	q No	qYes	When?_____
Other_____	q No	qYes	When?_____

FOR WOMEN ONLY:

Do you now, or have you ever had…?

Breast lumps	q No	qYes	When?_____
Nipple discharge	q No	qYes	When?_____
Breast pain or tenderness	q No	qYes	When?_____
Abnormal PAP smear	q No	qYes	When?_____
Cervical displasia	q No	qYes	When?_____
Vaginal discharge	q No	qYes	When?_____
Gonorrhea	q No	qYes	When?_____
Syphilis	q No	qYes	When?_____
Genital, oral or rectal herpes	q No	qYes	When?_____
Condyloma	q No	qYes	When?_____
Fibroids	q No	qYes	When?_____
Ovarian cysts	q No	qYes	When?_____
Sexual difficulties	q No	qYes	When?_____
Are you on birth control?	q No	qYes	When?_____

Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Age at first menses _____
Length of cycle in days _____
Duration of period in days_____

PMS symptoms	q No	qYes	When?_____
Painful menses	q No	qYes	When?_____
Clotting during menses	q No	qYes	When?_____
Bleeding between periods	q No	qYes	When?_____
Menopausal symptoms	q No	qYes	When?_____
Other_____	q No	qYes	When?_____