Acupuncture Kitchen **Health History Questionnaire** CONFIDENTIAL

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Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender	Date of Birth	Age	Eye Color:	Height:	Weight:
M F	_____ / _____ / _____				

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One*
(   )

Phone (Nighttime) # – **Home Work Mobile** *Circle One*
(   )

Social Security Number
_ _ _ _ _ _ _ _ _

Place of Employment

Occupation

Name & Phone Numbers of Partner:
Primary (   ) Alternate (   )

Name & Phone Numbers of Emergency Contact:
Primary (   ) Alternate (   )

E-Mail:

How did you hear about us? *Please circle one and write the name*

Current Patient: __________ Doctor: __________Advertisement: __________ Friend: ________Insurance: ___________ Other:____________

Have you received a Diagnosis for your condition(s)? Y / N If so what:
By Whom:

Have you had Acupuncture before? Y / N
Did you have a positive ☐ Experience ☐ Out come

	Severe	Moderate	Slight	Major Complaint(s), in order of **importance** to you:
1.	☐	☐	☐	___________________
2.	☐	☐	☐	___________________
3.	☐	☐	☐	___________________
4.	☐	☐	☐	___________________
5.	☐	☐	☐	___________________

When/how did this condition occur? Give dates if possible. 1) ___________________

2) ___________________ 3) ___________________

How do these conditions impair your daily activities? 1) ___________________

2) ___________________ 3) ___________________

Treatment(s) you have received for this condition: 1) ___________________

2) ___________________ 3) ___________________

What treatments helped the most? 1) ______________________________

2) ______________________________ 3) ______________________________

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food.	OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:	DIET & EXERCISE Check (√) all that apply.
Year	**Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)**		☐ Stress ☐ Environmental ☐ Heavy Typing ☐ Heavy Lifting ☐ Others:	☐ Regular Exercise
				☐ Low-Fat ☐ Low-Carb ☐ Vegetarian
				☐ Other:
				☐ Drink Coffee: Cups/Day
			Occupation: ______________	☐ Drink Soda oz/Day

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 5.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SUPPLEMENTS

Name	Purpose	How Long	Dose	How Often	Last Dose

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a “**C**” under the appropriate person’s column. “**P**” should be used to indicate a past problem. Leave blank those that do not apply. If any of the above family members are deceased, please list their age at death and cause. If you require more space, use the space below.

Notes:

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Anorexia / Bulimia											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_______________											
Other:___________________											

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst).
Leave blank if Not Applicable.

LIVER / GALLBLADDER

________ Irritability / Anger

________ Depression / Stress

_______ Poor Memory

_______ Loss of Hair

_______ Hearing Problems

_________ Low Resistance to Colds or Flu

_________ Sneezing

_________ Mild Fever Comes & goes

- ________ Visual Problems
- ________ Red / Dry / Itchy Eyes
- ________ Gall Stones
- ________ Dizziness
- ________ Blurred Vision
- ________ Feeling of Lump in Throat
- ________ Clenching of Teeth at Night
- ________ Muscle Cramping / Twitching
- ________ Tension
- ________ Joints/Neck/Shoulder Pain/Tight
- ________ Poor Circulation
- ________ Soft / Brittle Nails
- ________ Emotional Eater
- ________ Bad Taste
- ________ Bad Breath
- ________ Do you Crave: Sour

KIDNEY/ URINARY BLADDER

- ________ Urinary Problems
- ________ Bladder Infection
- ________ Dropped Bladder
- ________ Incontinence
- ________ Lack of Bladder Control
- ________ Weakness/ Pain in Lower Back
- ________ Decrease Bone Density
- ________ Feel Cold Easily
- ________ Cold Hands
- ________ Cold Feet
- ________ Low Sex Drive / Libido
- ________ Excess Sexual Desire

- ________ Fear
- ________ Hot Flash/ Night Sweating
- ________ Do you crave: Salty

Heart / Small Intestine

- ________ Heart Palpitations
- ________ Chest Pain
- ________ Insomnia / Sleep Problems
- ________ Easily Startled
- ________ Restlessness / Agitation
- ________ Vivid Dreams
- ________ Do you crave: Bitter

LUNG / LARGE INTESTINE

- ________ Bloody Cough
- ________ Dry Cough
- ________ Cough with Sputum
- ________ Nasal Discharge / Circle Color - White Yellow Green
- ________ Post Nasal Drip / Circle Color: White Yellow Green
- ________ Sinus Infection/ Congestion
- ________ Itchy, Red, or Painful Throat
- ________ Dry Mouth/ Throat/ Nose
- ________ Skin Rashes / Hives
- ________ Snoring
- ________ Grief / Sadness
- ________ Shortness of Breath
- ________ Allergies / Asthma
- ________ Emphysema
- ________ Bronchitis
- ________ Black / Blood in Stools
- ________ Constipation
- ________ IBS
- ________ Colitis/ Spastic Colon
- ________ Diarrhea
- ________ Do you Crave : Pungent

SPLEEN / STOMACH

- ________ Heaviness Anywhere in the Body
- ________ Fatigue on a Scale of 1(**low**) –10 (**high)**
- ________ Hard to get up in the Morning
- ________ Muscles Feel Tired Often
- ________ Edema (swelling) □ hands □ feet
- ________ Easily Bruising & Bleeding
- ________ Bad Breath
- ________ Nausea/ Vomiting
- ________ Difficulty Digesting Fatty Foods
- ________ Nausea/ Vomiting
- ________ Gas / Belching
- ________ Hemorrhoids
- ________ Constipation
- ________ Diarrhea
- ________ Abdominal Pain
- ________ Indigestion / Heartburn
- ________ Over - Thinking
- ________ Tendency to Gain Weight
- ________ Brain Foggy
- ________ Do you Crave: Sweet