



ACUPUNCTURE HEALTH HISTORY QUESTIONNAIRE

In order to provide you with the best possible care, please take the time to complete this questionnaire. Acupuncture works best when a specific complaint is placed in the context of your overall health. This information is confidential. If you have any questions, please ask. If there is anything not asked on this form, please bring it to my attention when we discuss your health.

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Street: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Family Physician and Address: \_\_\_\_\_  
Emergency Contact with Phone Number: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

Have you ever had acupuncture before? Yes \_\_\_\_\_ No \_\_\_\_\_

Main problem(s) you would like treated with acupuncture: \_\_\_\_\_

Have you ever been given a Western medical diagnosis for this problem? If so, please list:

What kinds of treatments have you tried for this problem? \_\_\_\_\_

Personal Medical History: Please check all that apply and list date of diagnosis.

- \_\_\_\_\_ Allergies \_\_\_\_\_ Arthritis \_\_\_\_\_ Asthma \_\_\_\_\_ Bronchitis
- \_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Depression \_\_\_\_\_ Seizures
- \_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Hepatitis \_\_\_\_\_ Heart Disease \_\_\_\_\_ Tuberculosis
- \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_ Obesity \_\_\_\_\_ Pneumonia
- \_\_\_\_\_ Shingles \_\_\_\_\_ Stroke \_\_\_\_\_ Thyroid Disease
- \_\_\_\_\_ Raynaud's Disease \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Chronic Fatigue

Other: \_\_\_\_\_

Surgical History: Please list and date, including childhood surgeries/traumas: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** Please list \_\_\_\_\_

**Current Medications:** Please list, including name, dosage and condition being treated.

**Family Medical History:** Please check all that apply

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Bronchitis   |
| <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> Obesity      |
| <input type="checkbox"/> Shingles          | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Shingles        | <input type="checkbox"/> MS           |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Chronic Fatigue     | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> High Blood Pressure |  |                                       |
| <input type="checkbox"/> Raynauds Disease  |  |  |                                       |

Other: \_\_\_\_\_

**Lifestyle:** Please note all that apply. Also please note frequency of use.

Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_

Caffeine: \_\_\_\_\_ Recreational Drugs: \_\_\_\_\_

Exercise: Please specify type: \_\_\_\_\_

Please describe your average daily diet, including snacks:

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

**General Symptoms:** Please check all that apply.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Fevers                      | <input type="checkbox"/> Night sweats                   | <input type="checkbox"/> Poor Sleep         |
| <input type="checkbox"/> Weight Loss                 | <input type="checkbox"/> Weight gain                    | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Food cravings               | <input type="checkbox"/> Bruise easily                  | <input type="checkbox"/> Bleed easily       |
| <input type="checkbox"/> Chills                      | <input type="checkbox"/> Fatigue                        | <input type="checkbox"/> Strong thirst      |
| <input type="checkbox"/> Strange taste in mouth      | <input type="checkbox"/> Sudden energy drop after meals |   |
| <input type="checkbox"/> Sweat easily during daytime | <input type="checkbox"/> Low Immunity/get sick often    |   |

**Skin and Hair:** Please check all that apply.

- |                                    |  |  |                                   |
|------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Dry skin  | <input type="checkbox"/> Eczema                          | <input type="checkbox"/> Rashes              | <input type="checkbox"/> Hives    |
| <input type="checkbox"/> Rosacea   | <input type="checkbox"/> Pimples                         | <input type="checkbox"/> Itchy skin          | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Dandruff  | <input type="checkbox"/> Brittle fingernails             | <input type="checkbox"/> Hair loss/ Thinning |                                   |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Change in skin texture or Moles |  |                                   |

Other hair or skin problems: \_\_\_\_\_

**Head:** Please check all that apply.

- |                                      |                                      |                                    |  |
|--------------------------------------|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Vertigo   | <input type="checkbox"/> Meniere's Disease |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Migraines |  |

**Eyes:** Please check all that apply.

- |                                    |                                      |  |  |
|------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Glasses   | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness                 | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye pain    | <input type="checkbox"/> Floaters/spots in front of eyes |  |
| <input type="checkbox"/> Dry eyes  |                                      |  |  |

**Ears:** Please check all that apply.

- |   |                                   |  |
|---|-----------------------------------|--|
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Earaches | <input type="checkbox"/> Hearing loss/Poor hearing |
| <input type="checkbox"/> Balance problems |                                   |  |

**Nose:** Please check all that apply.

- Sinus problems                       Postnasal drip                       Loss of smell
- Nose bleeds

**Jaw/Mouth/Throat:** Please check all that apply.

- TMJ                                       Grinding teeth                       Jaw pain
- Jaw clicking                       Mouth sores                       Dry mouth
- Bad breath                       Teeth problems                       Gum problems
- Sense of something stuck in throat                       Re-current sore throats

Other: \_\_\_\_\_

**Lungs, Heart. Chest:** Please check all that apply.

- Chest tightness                       Shortness of breath                       Difficulty inhaling
- Difficulty exhaling                       Chest pain                       Frequent sighing
- Cough                                       Frequent colds/flu                       Allergies
- Pneumonia                                       High Blood Pressure                       Blood clots
- Low Blood Pressure                       High cholesterol                       Phlebitis
- Irregular heart beat                       History of fainting                       Swollen hands
- Swollen feet                                       Cold hands/feet
- Heart valve problems

**Do you have a pacemaker?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Do you have any other heart problems?** Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please explain:

\_\_\_\_\_

**Digestive/Gastrointestinal:** Please check all that apply.

- Low appetite                                       Strong appetite                                       No appetite
- Nausea     Gas     Food cravings
- Heartburn     Belching     Vomiting
- Acid Reflux     Hiccups     Bloating
- Diabetes     Hypoglycemia     Diarrhea
- Indigestion     Constipation     Irritable bowel syndrome
- Crohn's Disease     Black stools     Hemorrhoids
- Urgency with bowel movements     Abdominal cramps or pain
- Chronic laxative use     Blood in stools     Energy drop after meals

**If you have diabetes, do you have any areas of neuropathy or numbness? How is your vision? Please list any secondary complications experienced from you diabetes.**

\_\_\_\_\_  
\_\_\_\_\_

**Genitourinary:** Please check all that apply.

- Frequent urination                       Urgent urination                       Incontinence
- Decrease in urinary flow                       Genital herpes                       Impotence
- Urinary tract infections                       Kidney stones                       Prostate problems
- Infertility/low sperm count                       Painful intercourse
- Loss or decrease in sexual drive
- Pain/burning with urination
- Feeling of incomplete urination

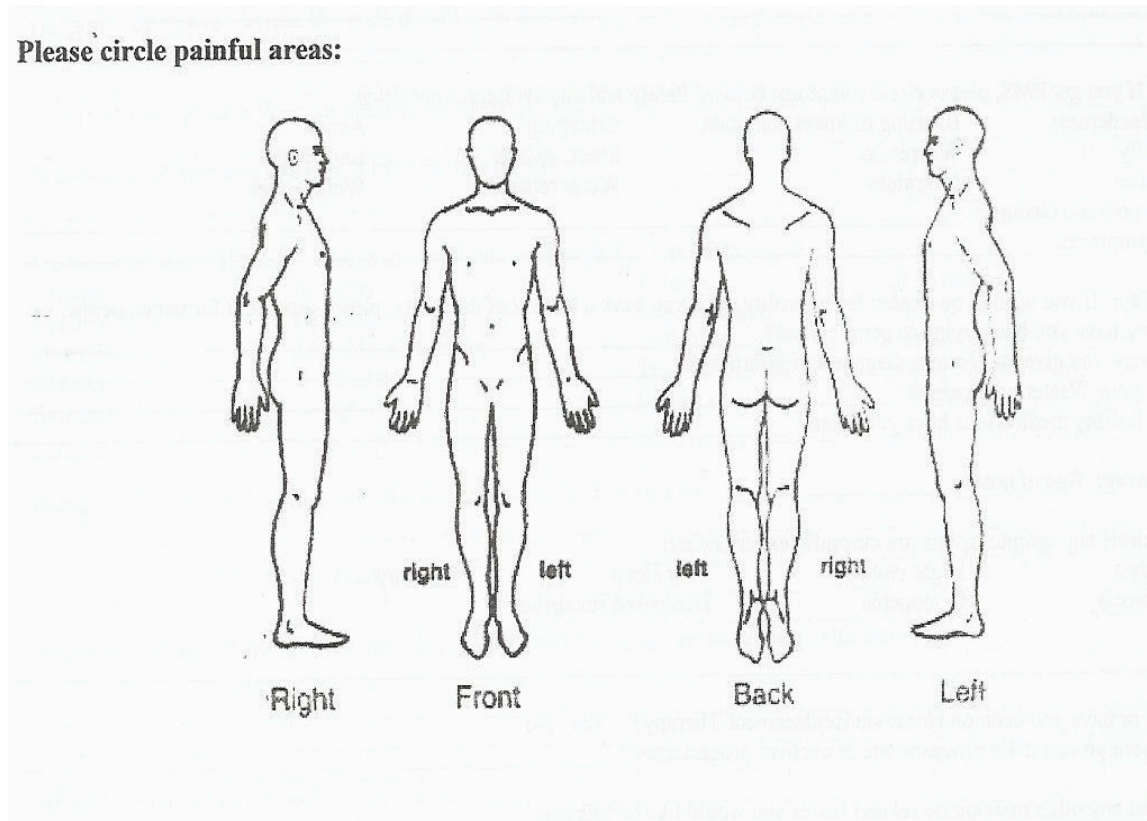
Other:: \_\_\_\_\_

**Musculoskeletal:** Please check all that apply.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Neck pain                  | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Low back pain            |
| <input type="checkbox"/> Hip pain                   | <input type="checkbox"/> Finger pain     | <input type="checkbox"/> Wrist pain               |
| <input type="checkbox"/> Elbow pain                 | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Rotator cuff pain        |
| <input type="checkbox"/> Knee pain                  | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Carpel tunnel syndrome   |
| <input type="checkbox"/> Repetitive stress syndrome |  | <input type="checkbox"/> Tight muscles or tendons |

Other: \_\_\_\_\_

**Please circle painful areas:**



**Neuropsychological:** Please check all that apply.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Seizures                       | <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Poor memory                    | <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Bad temper/Irritable           | <input type="checkbox"/> Stress         | <input type="checkbox"/> Numbness         |
| <input type="checkbox"/> Loss of coordination           | <input type="checkbox"/> Mental illness |   |
| <input type="checkbox"/> Post Traumatic Stress Disorder |   |   |

What, if any, are the major sources of stress in your life? \_\_\_\_\_

\_\_\_\_\_

How do you deal with or manage your stress on a regular basis? \_\_\_\_\_

\_\_\_\_\_

Please rate your current stress levels on a scale of 1-10, with 10 being the worst stress you have ever experienced.  
Please circle one.

1      2      3      4      5      6      7      8      9      10

Have you ever considered or attempted suicide? \_\_\_\_\_

Do you have any other neurological or psychological problems? \_\_\_\_\_  
\_\_\_\_\_

**OB-GYN:** Age of first menstrual period: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Number of days between periods: \_\_\_\_\_ Number of days period lasts: \_\_\_\_\_

Color of menstrual blood: (circle one) Bright red \_\_\_\_\_ Dark red \_\_\_\_\_ Purplish red \_\_\_\_\_ Other: \_\_\_\_\_

Do you have cramps with your period: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, are cramps: Strong \_\_\_\_\_ Dull \_\_\_\_\_

Do you have clots with your period: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, are clots: Large \_\_\_\_\_ Small \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_ Number of abortions: \_\_\_\_\_

Number of premature births: \_\_\_\_\_

Please check all that apply.

\_\_\_\_\_ Vaginal discharge      \_\_\_\_\_ Frequent yeast infections      \_\_\_\_\_ Birth control pills

\_\_\_\_\_ Fibroids      \_\_\_\_\_ Ovulatory or mid-cycle pain      \_\_\_\_\_ Ovarian cysts

\_\_\_\_\_ Vaginal sores      \_\_\_\_\_ Irregular periods      \_\_\_\_\_ No periods

\_\_\_\_\_ Short periods      \_\_\_\_\_ Long periods      \_\_\_\_\_ Mid-cycle spotting

\_\_\_\_\_ Heavy menstrual flow      \_\_\_\_\_ Light menstrual flow

Other: \_\_\_\_\_

**PMS:** If you get PMS, please check the symptoms below. Please add any symptoms not listed.

\_\_\_\_\_ Breast tenderness      \_\_\_\_\_ Bloating of lower abdomen      \_\_\_\_\_ Cramping

\_\_\_\_\_ Acne      \_\_\_\_\_ Irritability      \_\_\_\_\_ Weepiness

\_\_\_\_\_ Mood swings      \_\_\_\_\_ Back pain      \_\_\_\_\_ Headaches

\_\_\_\_\_ Migraines      \_\_\_\_\_ Water retention      \_\_\_\_\_ Weight gain

Other emotional changes: \_\_\_\_\_

Other symptoms: \_\_\_\_\_

**Infertility:** If you wish to be treated for infertility, or if you have a history of infertility, please provide information below.

How long have you been trying to get pregnant? \_\_\_\_\_

When were you given a Western diagnosis of infertility? \_\_\_\_\_

What is your Western diagnosis? \_\_\_\_\_

What infertility medications have you taken? \_\_\_\_\_

What infertility treatments have you tried? \_\_\_\_\_

How many of these treatments have you had? \_\_\_\_\_

**Menopause:** Age of onset: \_\_\_\_\_

Please check any symptoms you are currently experiencing.

\_\_\_\_\_ Hot flashes      \_\_\_\_\_ Night sweats      \_\_\_\_\_ Poor sleep      \_\_\_\_\_ Memory loss

\_\_\_\_\_ Osteoporosis      \_\_\_\_\_ Osteopenia      \_\_\_\_\_ Decreased sex drive

Other: \_\_\_\_\_

Are you or have you ever been on hormone replacement therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, were you on a daily Progesterone or cyclical Progesterone? \_\_\_\_\_

Please list any other menopause related issues you would like to address:  
\_\_\_\_\_