Today's Date______________________

# THE HEALING POINT ACUPUNCTURE CLINIC

# HEALTH HISTORY QUESTIONNAIRE

We hope you will answer the questions on this medical history form as thoughtfully as possible. Many of the questions that follow may not seem directly related to your main complaint or reason for seeking care. However, the answers to these questions, as well as the information you provide in the office, will determine the individualized approaches we take to begin your treatment.

ALL THE INFORMATION IN THIS QUESTIONNAIRE IS CONFIDENTIAL BY LAW

Name________________________________________________________ Date of Birth_______________________

Address___________________________________________________________________________________________

City________________________________________________State_______________Zip________________________

May we contact you at: Home (phone)__________________________(cell)___________________________________

Age_____________ Gender _____Female _____Male Email____________________________________________

Guardian if under 18___________________________________________________________________________

Occupation__________________________________________________________________________________

Hours worked per week_________________________________Is your complaint related to work ____yes _______no.

Employer: __________________________________________________________________________________

_______Married ________Partnership ________Single ________Separated _________Divorced _____Widowed

Live with: _______Spouse or partner _______Parents _______Children _________Friends ___________ Alone

Who to reach in case of emergency:______________________________________________________________

Relationship______________________________________Phone________________________________________

Email_____________________________________________________________________________________

How did you hear about our clinic?_______________________________________________________________

**Major complaints in order of significance to you:**

1. 
2. 
3. 
4. 
5. 
6. 

**How do these conditions impair your daily activity?**

**Patient Name**______________________________ Date of Birth________________

**Family History: Do you or anyone in your family have a history of the following?**

| | | | | | |
|---|---|---|---|---|---|
| **Cancer** | **Diabetes** | **Heart Disease** | **High Blood Pressure** | **Kidney Disease** | **Anemia** |
| **Epilepsy** | **Arthritis** | **Glaucoma** | **Tuberculosis** | **Stroke** | **Mental Illness** |
| **Asthma** | **Hayfever** | **Hives** | **Autoimmune Disease** | **Thyroid Problems** | **Skin Problems** |
| **Jaundice** | **STD's** | **Other:** | | | |

| **Physical Exams & Lab Tests:** | | | |
|---|---|---|---|
| Physical | Cholesterol | HIV/STD | Blood |

**Medications and Supplements:**

Please list any medications you are currently taking:

| Medication & dose: | Reason: | How long? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| Please list any supplements you are currently taking: | | |
| Supplement: | Reason: | How Long? |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Please indicate the use and frequency of the following:** | **How much?** | **How often?** |
| Coffee/Tea _____Yes _____No | | |
| Recreational drug _____Yes _____No | | |
| Tobacco _____Yes _____No | | |
| Alcohol _____Yes _____No | | |
| Water _____Yes _____No | | |
| Soda _____Yes _____No | | |
| | | |

List any allergies, food sensitivities or cravings that you have:

List any accidents, surgeries, or hospitalizations (include year):

**Patient Name**______________________________ Date of Birth____________________

# Symptoms

## Head:

Headache

_____ Entire head
_____ Back of head
_____ Forehead
_____ Temples
_____ Migraine

_____ Head feels heavy
_____ Loss of memory
_____ Light headedness
_____ Sensitivity to light
_____ Loss of smell
_____ Loss of taste
_____ Loss of balance
_____ Dizziness
_____ Loss of hearing
_____ Pain in ears
_____ Buzzing in ears

## Mid-Back

______ Mid-back pain
______ Muscle spasms
______ Pain between shoulder blades

## Lower Back:

Low back pain is worse when:

_____ working
_____ lifting
_____ stooping
_____ standing
_____ sitting
_____ bending
_____ coughing

_____ Pinched nerve
_____ Slipped disk
_____ Low back feels out of place
_____ Muscle spasms
_____ Arthritis

## Neck:

_____ Pain in neck
_____ Neck pain with movement
_____ Pinched nerve in neck
_____ Neck feels out of place
_____ Stiff neck
_____ Grinding sounds in neck
_____ Grating sounds in neck
_____ Popping sounds in neck
_____ Arthritis in neck
_____ Muscle spasms in neck

## Arms and Hands:

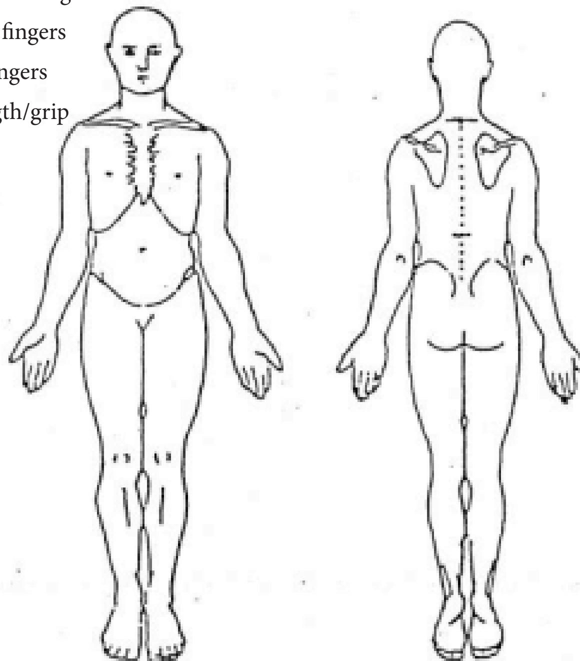
_____ R ______ L ______ Both
_____ Pain in upper arm
_____ Pain in forearm
_____ Pain in hands
_____ Pain in fingers
_____ Pinched nerve in arm
_____ Pins and needles in arms
_____ Fingers go to sleep
_____ Hands cold
_____ Swollen joints in fingers
_____ Sore joints in fingers
_____ Arthritis in fingers
_____ Loss of strength/grip

## Shoulders:

___R___L Pain in shoulder joint
___R ___L Pain across shoulders
___R ___L Bursitis
___R ___L Arthritis
___R ___L Muscle spasms in shoulder
___R ___L Can't raise arm
___R ___L Pain in forearms
_____ above shoulder level
_____ overhead
_____ Tension in shoulders
_____ Pinched nerve in shoulders

## General:

______ Nervousness
______ Irritable
______ Depressed
______ Fatigue
______ Feel run down
______ Loss of sleep
______ Loss of weight
______ Sudden weight gain



Mark Areas of Pain on Diagram

## Chest:

_____ Chest pain
_____ Tightness in chest
_____ Shortness of breath
_____ Pain around the ribs

## Abdomen:

_____ Nervous stomach
_____ Constipation
_____ Nausea
_____ Diarrhea
_____ Gas/Bloated
_____ Tenderness

## Hips, Legs & Feet:

HIPS & LEG:

_____ Pain in buttocks
___R ___L Pain in hip joint
___R ___L Pain down one leg
___R ___L Pain down both legs
___R ___L Leg cramps
___R ___L Pins & needles in legs
___R ___L Numbness of leg

KNEE PAIN:

___R___L Knee
___Inside _____Outside
___Front ___Back
_____ Swelling in knee
_____ Weakness in knee

FEET:

___R ___L Pain in foot
___R ___L Numbness of feet
___R ___L Numbness of toes
_____ Feet feel cold
_____ Cramps in feet
_____ Swollen ankles
_____ Swollen feet
_____ Painful joints in toes

**Patient Name**____________________________________________ Date of Birth__________________________

**TCM - Please check the following that currently pertain to you if you have symptoms in the following categories:**

## Category 1

___Difficulty breathing
___Loose stools
___Dry stools
___Excess phlegm
___Tuberculosis
___Sweating problems
___Smoke (# per day___)
___Sadness
___Difficulty concentrating
___Frequent colds/flu
___Psoriasis
___Sinitis/Rhinitis
___Shortness of breath
___Cough
___Rapid, Quick thinking
___Slow healing skin
___Pulmonary disease
___Nasal problems
___Constipation
___Melancholy
___Asthma
___Mucus in stool
___Diarrhea
___Chest congestion
___Wheezing
___Emphysema/COPD
___Bottle fed as child
___Allergies
___Other_______________

Sensitive to ___Smells ___Noise ___Clothing ___Energy __Other ________________________________________________

## Category 2

___Frequent cavities
___Memory problems
___Easily startled
___Sciatica
___Spinal column disease
___Knee pain
___Heat in chest
___Other dental problems
___Excessive hair loss
___Fatigue / lethargy
___Decreased will power
___Osteoarthritis
___Afternoon Flushes
___Lack of perspiration
___Kidney stones
___Frequent night urination
___Cold hands or feet
___Multiple Sclerosis
___Infertility
___Hot body temperatures
___Perspires easily
___Easily broken bones
___Lack of bladder control
___Depression
___Muscular dystrophy
___Sterility
___Excessive thirst
___Hot flashes
___Low back pain
___Fear
___Premature gray hair
___Cerebral Palsy
___Cold body temperature
___Night sweats
___Heat in hands or feet

___Unusual urine output (Please explain)________________________________________________

## Category 3

___Anger easily
___Tightness in chest
___Gall stones (currently)
___Headaches on side of head
___Liver spots
___Brittle/coarse hair or nails
___Cramping
___Menstrual cramping
___Hiccups
___TMJ
___Frustration
___Bitter taste in mouth
___Seizure
___PMS symptoms
___Substance abuse
___Distension/Bloating
___Irritable bowel
___Vertigo
___Belching
___Stiff neck & shoulders
___Depression
___Tingling sensation
___Convulsions
___Fibromyalgia
___Chronic fatigue
___Flushed face
___Sensitivity to greasy food
___Tinnitus
___Sour regurgitation
___Restless legs
___Irritability
___Numbness
___Skin rashes
___Nausea
___Parkinson's Disease
___Muscle spasms
___Migraines
___Insomnia
___Churning stomach
___Pain in the ribs
___Gall stones history
___Drink alcohol
___Tendonitis
___Migratory pain
___Twitching
___Tremors
___Difficulty staying asleep
___Frequent sighing

___Repetitive strain disorders (Please List)________________________________________________

## Category 4

___Mental confusion
___Restlessness
___Sores on tip of tongue
___Drink coffee ____cups/day
___Abdominal pain
___Phobias
___Cardiac pain
___Palpitations
___Dizziness
___Wake unrefreshed
___Dream disturbed sleep
___Hot flashes
___Poor circulation
___Psychosis
___Chest to shoulder pain
___Vertigo
___Difficulty falling asleep
___Heart problems
___Hot painful joint
___Nasal problems
___Rheumatoid arthritis
___Epilepsy
___Flushed face
___Anxiety
___Hearing problems
___Inflammation
___Tongue/Speech Prob.
___Spontaneous sweating
___Bitter taste in mouth
___Nightmares
___Cold limbs
___Pain down the arm
___Anemia
___Disturbed thinking
___Lack of joy/humor
___Shortness of breath

Other(please list)________________________________________________

## Category 5

___Low appetite
___Abrupt weight gain
___Over thinking/worry
___Vomiting
___Gurgling noises in stomach
___Chronic disease
___Loose stools
___Difficulty focusing
___Insomnia
___Excessive appetite
___Abrupt weight loss
___Worry
___Abdominal bloating
___Ulcer (diagnosed)
___Cancer
___Irritable bowel syndrome
___Non-breast fed
___Excess phlegm
___Acid reflux
___Fatigue after eating
___Bad breath
___Belching
___Burning sensation after eating
___Diabetes
___Weak muscles
___Fatigue
____Crohn's Disease
___Heartburn
___Easily bruised
___Stomach pain
___Passing gas
___Prolapsed organs
___Headaches
___Vein problems
___Mouth sores
___Hemorrhoids
___Nausea
___Hiccups
___Aching heavy limbs
___Indigestion
___Poor memory
___Bitter taste in mouth

**Patient Name**________________________________________ Date of Birth__________________________

## Females

| Age of menarche (1st period): | Age of last period (menopause): |
|---|---|
| Number of days in cycle: | Number of days of flow: |
| Color of flow: | Clots? _____Yes _____ No |
| Have you been diagnosed with any of the following conditions? | |

| Fibroids | Fibrocystic Breasts | Endometriosis |
|---|---|---|
| Ovarian cysts | Pelvic Inflammatory | Disease (PID) HPV |

| Are any of the following associated with your menstrual cycle? | | | |
|---|---|---|---|
| Cramping | Headaches | Discharge | Increased appetite |
| Stabbing pain | Mood changes | Nausea | Hot flashes |

| **Date of last gynecologic exam:** | | **Pap smear:** |
|---|---|---|
| Mammogram: | Results: | |
| Are you pregnant? ____Yes ____No | # of pregnancies: | # of abortions: |
| Do you wake at night to urinate? ____Yes ____No | | if so, how many times? |
| Other concerns: | | |

## Males

| Date of last prostate exam: | PSA results: |
|---|---|

| Other lab results: | | | |
|---|---|---|---|
| Dribbling urine | Incontinence | Groin pain | Delayed stream |
| Testicular pain | Decreased libido | Other | |
| Please Explain: | | | |
| Do you wake at night to urinate?____Yes ____No | | If so, how many times? | |
| Other concerns: | | | |

**Patient Name**________________________________________ Date of Birth__________________

## Food Habits

**Eating Out:** Do you eat out at restaurants? ______Frequently __________Occasionally ________Rarely_____Never.

**Home Meals:** Do you prepare meals at home? _______Yes _____ No.

If yes, how often? ____________________________________________________________

If yes, what type of food do you prepare? ____________________________________________

**Meal Habits:** Do you _____Skip meals often? _____Have regular meals? _____ Snack throughout the day?

_____Have irregular meals? _____Eat past 7pm?

**MSG:** Do you avoid foods/drinks that list "natural flavors" (which means hidden MSG)? _____Yes _____No.

**Water:** Do you drink tap water? _____Yes _____No.

If you have a home water purifier, when was the cartridge last changed?______________________

What brand of drinking water do you use?_____________________________________________

**Typical Food Intake:**

Breakfast:_______________________________________________________________

Lunch:__________________________________________________________________

Dinner:_________________________________________________________________

Snacks:_________________________________________________________________

To drink:________________________________________________________________

## Exercise:

Do you exercise? _____Yes _____No. If yes, what type/s______________________________

How many days per week?_________________ How many hours?______________________

## Sleep:

What time do you go to bed?_______________. Do you go to bed at the same time every night?_____Yes _____No.

How many hours per night do you sleep?______________. Do you sleep through the night?_____Yes No.

Do you wake feeling refreshed?_____Yes _____No. Do you feel groggy when you wake? _____Yes _____No.

Do you have vivid dreams when you sleep? _______Yes _____No.

Do you have nightmares? _____Never _____Sometimes_____Often.

Do you wake naturally, or do you wake to an alarm? ________________________________________

## Pets:

**Do you have pets?** _____Yes _____No. If so, what kind and how many?

Is/are the pets allowed in the house? _____Yes _____No _____On your bed? _____Yes _____No

**Patient Name**______________________________________________ Date of Birth_____________________

## Context of Care Review

Why did you choose this clinic?

What three expectations do you have from your first visit to our clinic?
1.
2.
3.

What are your long term goals in working with our clinic?

What is your present level of motivation to address any underlying causes of your signs and symptoms?
Rate from 0 to 10, 10 being 100% motivated.

0% 1 2 3 4 5 6 7 8 9 10 100%

What behaviors and lifestyle habits do you currently engage in regularly that you believe contribute to and support your health?

What potential obstacles to making lifestyle changes or embarking on an intensive therapeutic program do you foresee?

What do you love to do that gives you a sense of satisfaction?
**0=no fulfillment/10=great fulfillment**

| | |
|---|---|
| Career | |
| Money | |
| Health | |
| Significant Other/ Romance | |
| Fun & Recreation | |
| Family & Fiends | |
| Friends | |
| Physical | |
| Spiritual | |
| Environment | |

**Have you received acupuncture therapy before?** _____Yes ____No

If yes, when?______________________________________________

With whom? ______________________________________________

For what condition?

Signature:____________________________________________________________________

*Thank you for your time and effort. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page or another sheet of paper.*