THE ATLANTIC CENTER
FOR ACUPUNCTURE & ORIENTAL MEDICINE

Health History Questionnaire

Important: Complete this document as thoroughly as possible.
All information is strictly confidential

I . **General Patient Information** Date: ___/____/____

Name: _____

Address:_____

City, State, ZIP:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address:_____ Age: _____

Date of Birth: _____/_____/_____ Place of Birth:_____

Guardian (if under 18): _____

Gender: M F Height: ____' ____" Weight: ____lbs.

Health Insurance: _____ Driver's License Number: _____

Occupation: _____ Employer:_____

How did you hear about our office?_____

Other physicians/therapists seen for this condition?_____

Medications (if any): _____

_____

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

_____

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

	Condition	**Severe**	**Moderate**	**Slight**
1				
2				
3				
4				
5				
6				
7				

Health History Questionnaire

How do these conditions impair you daily activities?_____
_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

Recent tests: (please indicate test results and date below)
□Physical □Cholesterol □Prostate □Blood (which?)
□HIV/STD □Pap Smear □Mammography □Other

Test Results and Date:_____

□Diabetes	□Allergies	□Glaucoma	□Rheumatic Fever
□Heart Disease	□CVA (stroke)	□Vein condition	□Thyroid disorder
□Asthma	□Pneumonia	□Tuberculosis	□Emphysema
□Jaundice	□Gonorrhea	□Mumps	□Bleeding Tendency
□Syphilis	□Measles	□Chicken Pox	□Nervous Disorder
□Meningitis	□HIV	□Polio	□Mononucleosis
□Epilepsy	□High Fever	□Hepatitis	□Multiple Sclerosis
□Paralysis	□Cancer	□Migraines	□High blood pressure
□other lung illness	□other liver illness	□other heart disease	□other kidney illness

□other: _____

Immunizations:_____

Surgeries:_____

III. Familly History

Family Member	Alive	Deceased	Present health or cause of death
Father			
Mother			
Sister			
Sister			
Brother			
Brother			
Spouse			
Child			
Child			
Child			

Where are you in the birth order: ___first, ___ last, ___ middle, ___ only

Check the following that have occurred in your blood relatives:

□Diabetes	□Cancer	□Heart Disease	□High Blood Pressure
□Allergies	□Tuberculosis	□Obesity	□Bleeding Tendency
□Alcoholism	□Nervous Illness	□Mental Illness	□Kidney Disease
□Stroke	□Other _____		

IV. Patient Profile

Is the pain: □Sharp □Burning □Aching
□Cramping □Dull □Moving
□Fixed Other:_____

Do the following lessen the pain?
□Pressure □Cold □Heat
□Exercise □Other: _____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have problem with that organs function)

<u>Overall temperature (Kidney Function)</u> __Cold hands __Cold fingers __Cold feet __Cold toes __Sweaty hands __Sweaty feet __Hot body temperature (sensation) __Cold body temperature (sensation) __Afternoon flushes __Night sweats __Heat in the hands, feed and chest __Hot flashes any time of the day __Thirsty / __Take water to bed __Perspire easily __Lack of perspiration	<u>Overall energy (Lung, Kidney function)</u> __ Shortness of Breath __Difficulty keeping eyes open in the daytime __General weakness __Easily catch cold __Low energy __Feel worse after exercise
<u>Overall blood (Liver, Spleen Heart function)</u> __Dizziness __Seeing floating black spots	<u>Heart function:</u> __Palpitations __Anxiety __Sores on the tip of the tongue __Restlessness __Mental confusion __Chest pain traveling to the shoulder __Frequent dreams __Wake un-refreshed __Drink coffee (# cups/day: ____)

Spleen function: __Low appetite __Abrupt weight gain __Abrupt weight loss __Abdominal bloating __Abdominal gas __Gurgling noise in the stomach __Fatigue after eating __Prolapsed organs (previously diagnosed, which organs: _____) __Easily bruised __Hemorrhoids __Pensive __Over-thinking __Worry	Spleen, Stomach, Large Intestine, Small Intestine function: __Loose stools __Constipated __Incomplete bowel movement __Diarrhea __Blood in the stools __Mucous in the stools __Undigested food in the stools
Lung function: __ Nasal discharge (Color:_____) __ Cough __ Nose bleeds __ Sinus congestion __ Dry: __ mouth, __ throat, __nose, __skin __ Allergies(List: _____) __ Alternating fever and chills __ Sneezing __ Headache Location:_____) __ Overall achy feeling in the body __ Stiff neck, __ Stiff shoulders __ Sore throat __ Difficulty breathing __ Smoke cigarettes (# of cigarettes per day:_____) __ Sadness/Grief __ Melancholy	Dampness Trapped in the Body: __General sensation of heaviness in the body __Mental heaviness __Mental sluggishness __Mental fogginess __Swollen hands __Swollen feet __Swollen joints __Chest congestion __Nausea __Snoring
Eyes (Liver Function): __Itchy __Bloodshot __Hot __Dry __Watery __Gritty __Blurry vision __Decreased night vision __Near-sighted __Far-sighted	Stomach Function: __Burning sensation after eating __Large appetite __Bad breath __Mouth (canker) sores __Bleeding, swollen or painful gums __Heartburn, __Acid regurgitation __Ulcer (diagnosed) __Belching, __Vomiting __Hiccoughs __Stomach pain
Kidney, Urinary Bladder Function: __Frequent cavities __Easily broken bones __Sore knees __Weak knees __Cold sensation in the knees	Liver, Gall Bladder Function: __Alternating diarrhea and constipation __Chest pain __Tight sensation in the chest __Bitter taste in the mouth __Anger easily

__Low back pain __Memory problems __Excessive hair loss __Low-pitched ringing in the ears __Kidney stones __Bladder infections __Wake during the night twice or more to urinate __Lack of bladder control __Fear __Easily startled <u>Urination:</u> __Normal color, __Dark yellow, __Clear, __Reddish, __Cloudy __Scanty, __Profuse __Strong odor, __Burning, __Painful __Discharge, __Difficult, __Painful, __Urgent	__Frustration, __Depression, __Irritability __Frequently unable to adapt to stress (What causes the stress? _____ __Skin rashes __Headache at the top of the head __Tingling sensation __Numbness __Muscle spasms __Muscle twitching __Muscle cramping __Seizures <u>Libido</u>: ___ Normal ___ High ___ Low

Men Only:

__swollen testes __testicular pain __impotence __premature ejaculation
__feeling of coldness or numbness in the external genitalia __other_____

Women Only:

Regular menstrual cycle? ___Y___N
Number of children: ___
Age of first menstruation: ___
Average number of days of flow: ___
___Vaginal discharge

Pregnant? ___Y___N
Number of pregnancies: ___
Age of menopause (if applicable):___
Average number of days of entire cycle: ___
___ Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

__nausea __vomiting __water retention __breast swelling
__food cravings __headaches __migraines __breast tenderness
__depression __irritability __anxiety __other emotions _____
__dull pain, where?_____ __sharp pain, where?_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow(normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

ALL PLEASE FILL OUT:

Other comments:_____

_____

Patient Signature:_____

Acupuncturist Signature: _____