Acupuncture Center
OF SOUTHERN NH, LLC

Health History Questionnaire

Date:______________________
Name:____________________________ Sex:________ DOB:_____________
Street address:___________________________________
City:______________________ State:____________ Zip:____________
Phone number:______________

Height:__________________Weight:___________________
Occupation:___________________________

Family Physician:______________________________
Referred by:__________________________________
Emergency Contact:_____________________________ Relationship:_____________
Emergency contact phone number:_________________

What is the main problem you would like help with?
____
____

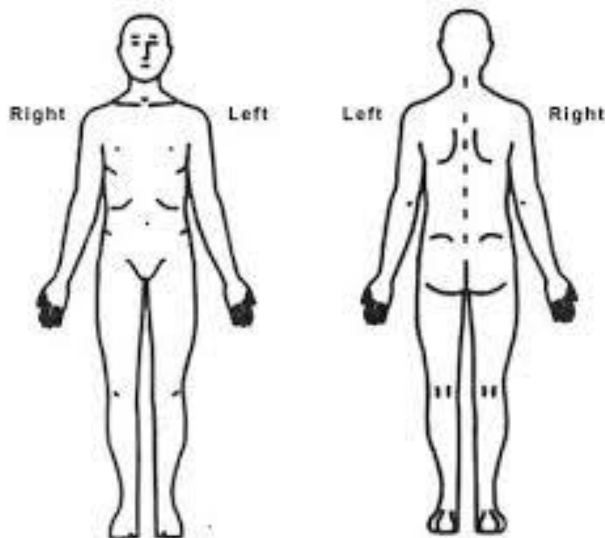
When did this problem begin?
____
____

To what extent does this problem interfere with your activities of daily living, work, sleep or sex life? ____
____

Have you been given a diagnosis for this problem? If so, what?
____

What other treatments have you tried for this problem?
____

Have you ever been treated by acupuncture or Oriental medicine before? _____________



Mark the areas of your body where you feel the described sensation. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X **Numbness**
+ **Burning**
* **Pin & Needles**
= **Stabbing**

Name:______________________________ Date: __________________________

Past medical history:

Have you been diagnosed with any of the following? (circle all that apply):

Cancer	Diabetes	High blood pressure	Heart disease	Asthma
Seizures	Venereal disease	Thyroid disease	Hepatitis	Stroke

Other (please specify): ____

Surgeries: ____

____

Significant traumas (motor vehicle accidents, falls, bone fractures, etc.): _____________

____

Allergies:____

Medications you now take, including over the counter and herbal supplements:

____

____

Occupational stress (chemical, physical or emotional): ____________________________

____

Do you have a regular exercise routine? If yes, please describe: ____________________

____

Have you ever been on a restricted diet? If yes, please describe: ____________________

____

Please describe your average daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Do you smoke? If so, how much: ____

How many caffeinated beverages do you consume daily: __________________________

How much water do you drink daily? ____

How much alcohol do you drink? ____

Do you use any drugs for non-medical purpose? If so, please describe: ______________

____

Please circle if you have had any of the following in the last 3 months:

General:

Fever	Peculiar taste or smells	Strong thirst (hot or cold drinks)
Sweat easily	Cravings	Poor sleep
Night sweats	Change in appetite	Fatigue
Chills	Weight loss	Sudden drop in energy (time of day?)
Bleed/bruise easily	Weight gain	

Name: ________________________________ Date:_______________

Skin and hair:

Rashes	Ulcerations	Hives
Itching	Eczema	Acne
Dandruff	Hair loss	Recent moles

Change in skin or hair texture: ____

Any other skin or hair problems? ____

Head, eyes, ears, nose, throat:

Dizziness	Concussions	Migraines
Glasses	Eye strain	Eye pain
Poor vision	Night blindness	Color blindness
Cataracts	Blurry vision	Spots in front of eyes
Ringing in ears	Poor hearing	Earaches
Sinus problems	Nose bleeds	Recurrent sore throat
Grinding teeth	Facial pain	Sores on lips/in mouth
Teeth problems	Jaw clicks	Headaches

Any other head or neck problems? ____

Cardiovascular:

Chest pain	Fainting	Blood clots
Phlebitis	Irregular heart beat	Cold hands or feet
High blood pressure	Low blood pressure	Peripheral Artery Disease
Swelling of hands	Swelling of feet	Varicose veins

Any other heart or blood vessel problems: ____________________________________

Respiratory:

Asthma	Shortness of breath	Difficulty breathing
Cough	Coughing blood	Pain with deep breath
Bronchitis	Pneumonia	Wheezing

Difficulty breathing while lying down

If you are producing phlegm, what color is it? ___________________________________

Any other lung or breathing problems: ____

Gastrointestinal:

Nausea	Vomitting	Heartburn/indigestion
Diarrhea	Constipation	Blood in stools
Rectal pain	Hemorrhoids	Gas
Belching	Bloating	Bad breath
Bleeding gums	Chronic laxative use	

Any other problems with your stomach or intestines: _____________________________

Name: ______________________________ Date: _________________

Urinary:

Frequent urination	Painful urination	Kidney stones
Urgency to urinate	Blood in urine	Incontinence
Wake up to urinate	Decrease in flow	

What color is your urine: _______________________

Any other problems with your urinary system? _________________________________

Male reproductive:

Impotence	Premature ejaculation	Spermatorrhea
Testicular pain	Testicular injury	Prostatitis
Prostate Cancer	Benign Prostatatic Hypertrophy	
Low sperm count	Low motility	
Sore on genitals	STDs	

Any other reproductive problems? *____*

Female reproductive:

Are you pregnant? _________________________

Is it possible you are pregnant? ___________________

Age of first menses: __________ Duration of menses: __________________

Time between menses: ________________

Number of pregnancies: _________ Number of live births: ________________

Number of premature births: ___________ Miscarriages: ________________

Abortions: ____________

Age of menopause: ____________

When was your last GYN exam? _____________________________________

Do you practice birth control? If so what and for how long? _______________

____

Do you have:

Breast lumps	Vaginal discharge	Sores on genitals
Irregular periods	Painful periods	Heavy bleeding
Light bleeding	Infertility	STDs
Western Infertility Treatment		

Changes in body or psyche prior to menstruation? _________________________

Any other reproductive problems? _____________________________________

Musculoskeletal:

Neck pain	Hand/wrist pain	Foot/ankle pain
Shoulder pain	Hip pain	Muscle pain
Back pain	Knee pain	Muscle weakness

Any other muscle, joint or bone problems? _______________________________

Name: _________________________ Date: ___________________

Neurological:

Seizures	Stroke	Concussion	Dizziness
Numbness	Tremors (where?)	Loss of balance	Poor memory
Lack of coordination			

Any other neurological problems? ____

Psychological:

Depression	Anxiety	Fearful	Sadness
Easily angered	Easily worried	Easily susceptible to stress	
Overly joyful			

Have you ever been treated for emotional problems? _________________________

Have you ever considered or attempted suicide? _____________________________

Any other psychological problems? ____

If there is anything you wish to bring to our attention that has not been asked on this form, please mention it here. ____

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