Acupuncture Pain Clinic

Health History Questionnaire

Date: _____

Please help us provide you with a complete evaluation by taking the time to complete this questionnaire carefully. All of your answers and remarks are kept confidential. If there is anything you wish to bring to my attention which is not asked here, please write in the comments section. THANK YOU VERY MUCH!. (Please write legibly.)

Name: _____Date of Birth: _____Gender: M ___F ___
Phone: (Home): _____ (Work): _____
Address: _____
City: _____ State: _____ Zip: _____
E-Mail: _____ SS#: _____

Would you like to receive our e-newsletter with supportive health information (only once per season)? Y / N

Insurance
Subscriber's Name:_____Date of Birth:_____
Company Name: _____ ID#: _____

Auto Accident
Date of Accident: _____ Claim #: _____
Adjuster's Name: _____ Phone: _____

Height: _____ Weight: _____ Marital Status: _____
Emergency Contact: _____ Phone: _____
Whom may we thank for referring you? _____
Have you been treated by Acupuncture or Chinese Herbal Medicine before? Yes _____ No _____
By Who? _____

Main problem(s) you would like me to help with: _____
_____
How long have you had this condition? _____
What was the cause or reason of current condition, if you can think of any? _____
_____
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc?)
_____
Symptoms are relieved by: _____
Symptoms are made worse by: _____

Have you been given any diagnosis by any physician? If yes, please write:
_____
What kind of treatment have you tried for this problem? _____
_____
Did this treatment work? _____

Please check all of these conditions that apply to you:
____ AIDS/HIV ____Cancer ____Lyme Disease ____Seizures____High Blood Pressure
____Alcoholism ____Diabetes ____Multiple Sclerosis ____Tuberculosis_____Thyroid Disorder
____Allergies ____Emphysema ____Pacemaker ____Asthma____Heart Disease ____Polio
____Lymph Nodes removed ____Birth Trauma____Hepatitis A/B/C ____Rheumatic Fever
____Herpes I / II ____Scarlet Fever____Epstein Bar Virus ____Mononucleosis
____Cyclo Megla Virus ____Prosthetics____Implants, Other:_____
Surgeries or significant dental work (type of and date):
_____
Birth history (prolonged labor, forceps delivery, etc.)
_____
Allergies (drugs, chemicals, foods/result):_____
Family medical history (check):
____Diabetes____Cancer____High blood pressure____Heart disease ____Stroke____Seizures
____Asthma ____Allergies, Other_____
Significant trauma (auto accident, falls, loss of family etc. / date):_____
_____
Medications, Herbs, Supplements **(**List those you have taken in the last 2 months):
Name_____Reason _____How long and Dose _____
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Do you exercise regularly? Yes _____ No_____ If yes, what and how often a week:
_____
Have you ever been on a restricted diet? If yes, what and how long? _____
_____
Please describe your average daily diet:
Morning: _____
Afternoon: _____
Evening: _____
Snacks_____
Special diet_____ 3 worst foods you eat_____
Smoke cigarettes? Y/N How much?_____
Smoke cigarettes in the past? Y/N How many years? _____How many packs?_____
How often do you have?
Sugar/Sweet: _____ day/wk. Dairy (milk, cheese, yogurt): _____ day/wk.
Wheat (wheat products): _____ day/wk. Alcohol: _____ day/wk
How many cups/glasses do you have daily?: Water: ____ Soda: ____ Coffee/Tea: ____
Use recreational drugs? Y/N What and how often?_____
Have an addiction? Y/N To what and how long?_____
Been outside the U.S. in past 12 months? Y/N Where?_____
Are you always thirsty?: Yes:____ No: ____ Do you prefer drinks hot/cold?
Rate your taste preference 1 to 5 (1: like most to 5: dislike):
Salty: _____ Sour: _____ Bitter: _____ Spicy: _____Sweet:_____