HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, M.I.)*		❒ M ❒ F	DOB:
Address:		City/ ST/ Zip:	
Email address:		Monthly acupuncture newsletter, notice of special events (1-3x/year)? ❒ Y ❒ N	
Home phone:	Cell phone:	Social Security No.	
Preferred method of contact: *(Circle one)*	home / cell / work phone / other:		
Name of emergency contact:	Phone:	Relation to patient:	
Marital status:	❒ Single ❒ Partnered ❒ Married ❒ Separated ❒ Divorced ❒ Widowed		
Height:	Weight:	Occupation:	Employer:
Primary Care Physician:	Office Phone:	Date of last physical exam:	

How did you hear about us? Referred by: _____

Phone book / Newspaper ad / Brochure / Business card / Saw signs (drove by) / Other:_____

Websites: www.Acufinder.com / www.WellbeingCenterforHealth.com / Insurance provider list or webpage:_____

Other website: www._____ Web search: _____

INSURANCE INFORMATION

❒ I do not have insurance, or I am paying cash at time of service and prefer that my insurance **is not** billed for these services. Initial here: _____.

❒ Please bill my insurance and I will pay the remaining balance and co-pay.

Insurance carrier:	Group/Policy #:	Subscriber ID#:
Subscriber name:	Relation to Patient:	Subscriber DOB:
Insurance billing address:		
Insurance phone #:	# Acup. visits:_____ pcy; Deduc:$_____ ❒ Not subj. Rem: Co-pay:$____, Co-ins:____/____%	

PERSONAL HEALTH HISTORY

Childhood illnesses: ❒ Measles ❒ Mumps ❒ Rubella ❒ Chicken pox ❒ Rheumatic fever ❒ Polio

Surgeries

Year	*Reason*	*Year*	*Reason*

Other Hospitalizations, Auto accidents, Trauma, Falls

Year	*Reason*	*Year*	*Reason*

Main Conditions you would like us to help you with:

Main Condition	*Started when?*	*Therapies tried*

Include any other medical history not described above.

List your current prescribed drugs and over-the-counter drugs **Include vitamins, herbs, inhalers, CPAP machine, etc.**

Medication	*Dosage*	*For what condition?*	*Medication*	*Dosage*	*For what condition?*
1			5		
2			6		
3			7		
4			8		

Allergies
to Food; Seasonal; Environmental:
to Medications:

Other concerns			
Check if you have, or have had, any significant symptoms in the following areas and briefly explain.			
❒ Skin	❒ Throat	❒ Intestinal	Recent changes in:
❒ Head/Neck	❒ Lungs	❒ Bladder	❒ Weight
❒ Ears	❒ Chest/Heart	❒ Bowel	❒ Energy level
❒ Nose	❒ Back	❒ Circulation	❒ Ability to sleep
❒ Other pain/discomfort:			

Circle and mark all applicable current (C) or past (P) health conditions.					**Disorders/Disease of the:**
Asthma	Glaucoma	Bleeding disorder	Nervous disorder	Thyroid disorder	Heart
Cancer	Hepatitis	Jaundice	Paralysis	Tuberculosis	Kidney
Diabetes	High fever	Meningitis	Pneumonia	Ulcer	Liver
Emphysema	High blood pressure	Migraines	STDs_____	Vein condition	Lung
Epilepsy	HIV/AIDS	Mononucleosis	Stroke (CVA)		Spleen
Other major illnesses not listed above:					Stomach

Family Medical History Check all that apply in your immediate family					
❒ Allergies	❒ Cancer	❒ Heart disease	❒ High blood pressure	❒ Stroke	❒ Seizures
❒ Asthma	❒ Diabetes	❒ Other health conditions:			

Lifestyle		
Do you have a regular exercise program? ❒ Y ❒ N	If yes, describe:	
Are you on a restricted diet? ❒ Y ❒ N	If yes, describe:	
How much water do you drink daily?	How much alcohol per week?	
How many caffeinated drinks per week?	Coffee / Tea / Soda / Other	
Do you smoke? ❒ Y ❒ N	If yes, how many cigarettes per day?	
Occupational stress (chemical, physical, psychological, etc.):		
Please describe your typical daily diet	Lunch:	Dinner:
Breakfast:		
Snacks (eaten at what time):		

Genitourinary Health	
Check if you experience any of the following. Have you seen your Primary Care Physician for any of the problems indicated?	
❒ Get up at night to urinate _____ times	**(Men only)**
❒ Decreased force of urination	❒ Burning discharge from penis
❒ Problems emptying bladder completely	❒ Testicular pain or swelling
❒ Pain or burning with urination	❒ Difficulty with erection
❒ Blood in urine, or tea-colored urine	❒ Premature ejaculation
❒ Sensation of coldness or numbness in external genitalia	❒ Other concern:
❒ Kidney, bladder, or prostate infection within last 12 months	Date of last prostate and rectal exam: _____

Please sign and date below. **Women please continue to the next page.**

I, _____, certify that the above information is correct to the best of my knowledge.

Signature: **Date:**

Patient Chief Health Complaints

Name: _____ Date: _____

Please describe your current problem: _____

_____

How did this problem begin? _____

_____ Date it began: _____

What makes it better? _____

What makes it worse? _____

Do you have any range of motion restrictions? _____

What treatment(s) have you had for this condition? _____

What are your goals with acupuncture? _____

How bad is your pain? 0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

How often are your symptoms present? ❒ Constantly ❒ Frequently ❒ Occasionally ❒ Intermittently

Describe your current pain symptoms:

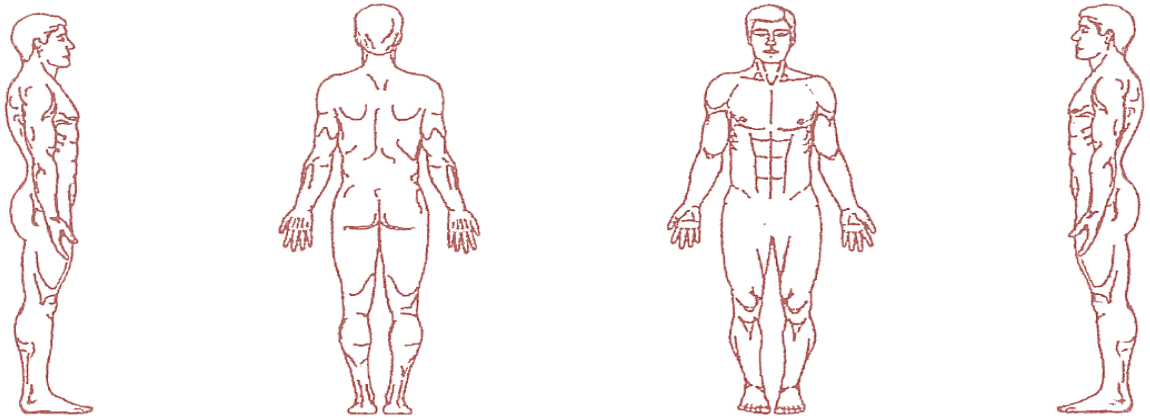
❒ Shooting	❒ Numbness	❒ Dull ache	❒ Sharp or Stabbing
❒ Throbbing	❒ Tingling	❒ Burning	❒ Moves around, "changes"
❒ Radiating	❒ Weakness	❒ Soreness	❒ Stiff or Tight

Can you perform your daily <u>home</u> activities ❒ without pain ❒ w/ pain -- explain _____

Can you perform your daily <u>work</u> activities ❒ without pain ❒ w/ pain -- explain _____

How is the quality of your sleep? _____ Hours of sleep lost _____

Please mark on the figures where you have symptoms of pain, numbness, tingling, etc.



Patient Signature: _____ Date: _____