AcuHealth

Acupuncture and Herbal Medicine

Health History Questionnaire

Please help me provide you with a complete evaluation by taking time to fill out this questionnaire carefully.
All of your answers will be held CONFIDENTIAL. If you have any questions, Please Ask.

Results may be experienced within 1 or 2 treatments, but more likely to be experienced after a course of several treatments. The exact number depends upon your body's response to this healing modality, its internal integrity and the degree of damage to the body. The therapeutic benefits of the treatments will build upon themselves to help you maintain a more optimal level of health.

Name: ______________________________ **Date:** ____________

Main Complaint: What would you like help with today? (Describe in your own words what you experience):
____

____

When did this problem begin? ______________________________

If you have been given a diagnosis by a Doctor for this problem, what is it? ______________

What types of treatment have you tried? ______________________________

____

Have you ever had acupuncture or oriental medical treatment before? If so, when and for what condition?

____

High blood pressure___ Seizures____ Asthma___ Heart disease _____
Rheumatic Fever___ Thyroid problems___ Herpes___ Kidney Stones___
Venereal disease___ Chronic fatigue syndrome___ Gallstones___
Parasites___ Mononucleosis___ Other (please specify)
Accidents/Surgeries (Please include details)______________________________

____

What scars do you have? Are they painful? ______________________________

____

Allergies: (drugs, chemicals, foods, environmental) ______________________________

____

Do You Have A Pacemaker? ____
Do you have a Heart Condition of any sort? ____

Have you ever taken antibiotics for a long period or frequently? If so, when and how long?
____

Do you have a regular exercise program? (please describe) ____

____

How much of the following do you consume *per* day? *All information is held STRICTLY CONFIDENTIAL.*
Coffee ___cups Tea ___cups Soft drinks ___cans/bottles
Beer ___cans/bottles Liquor ___ oz Wine___ glasses
Have you ever been drug or alcohol dependent? ____ If so, when? ___________________________________
Do you use drugs for non-medical purposes? If so, please describe____________________________________

FAMILY MEDICAL HISTORY
Significant family illnesses: Diabetes___ Cancer___ High blood pressure _____
Asthma____ Allergies_____ Depression___ Alcoholism____ Stroke ____Thyroid _______
Miscarriage____ Heart disease____ Osteoporosis _____
Mental health problems___ Other (please specify) _______________________________

Female: Please describe to the best of your ability
Menses: Date of last: ______________ Now pregnant _______ Age at menarche: __________
Days in cycle: ______ Color (red, bright red, brown, etc) ______________________________
Clots (color & size): _____________________ Amount of Flow: ________________________
Pain (severity & when): ____
Midcycle pain: _______ Breasts tender: ______ Cravings for: ___________________________
Irritable: _________ Fatigue: _______ Mood changes: _________________________________
Sexual energy: _________________ Birth control: ___________
Pregnancies: ________ Full term: __________ Premature: __________ Miscarriage/abortion: ___________
Menopause/date of last menses:_____________ Hot Flashes:________ Night sweats: ___________________
Vaginal discharge: When: ___________ Discomfort: _________ Color: ___________ Smell: ___________
Diseases: (presently or past) ____

Male: Please describe to the best of your ability
Prostate Problems: ____
Impotence: ____ Premature ejaculation: __________________
Diseases (presently or past): _____________________________ Sexual energy: ________________________

The above information is true to the best of my knowledge.

Signature____