ANCIENT POINTS ACUPUNCTURE & HERBS

HEALTH HISTORY QUESTIONNAIRE

Date_____

Please fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you.

Name _____**Date of Birth**_____

Phone (main) _____ **(other)** _____**Email**_____

Address _____

Occupation_____ **Marital Status**_____ **Referred by**_____

Emergency Contact (Name & Phone) _____

Main Problem(s) you would like us to help you with_____

_____

How long ago did this problem begin? (please be specific)_____

To what extend does this problem **interfere with your daily activities** (ex: work, sleep, etc.)?

_____

Have you been **given a diagnosis** for this problem? If yes, what is it?_____

What kinds of treatment have you tried? _____

PAST MEDICAL HISTORY (please include date)

Significant Illness

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Rheumatic Fever

☐ Hepatitis ☐ Seizures ☐ Thyroid Disease ☐ Venereal Disease ☐ Other _____

Hopitalization/Surgeries_____

Significant trauma (auto accidents, falls, etc.) _____

Allergies (drugs, chemicals, food, etc.) _____

FAMILY MEDICAL HISTORY

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke

☐ Asthmas ☐ Seizures ☐ Allergies ☐ Other_____

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Medicines taken within the last two months (drugs, vitamins, herbs, etc.) _____

_____

Occupational stress (chemical, physical, psychological, etc.) _____

Do you have a **regular exercise** program? If yes, please describe it. _____

Do you follow any type of **special diet**? If yes, what kind? _____

Please describe your **daily diet**?

Morning _____

Afternoon _____

Evening _____

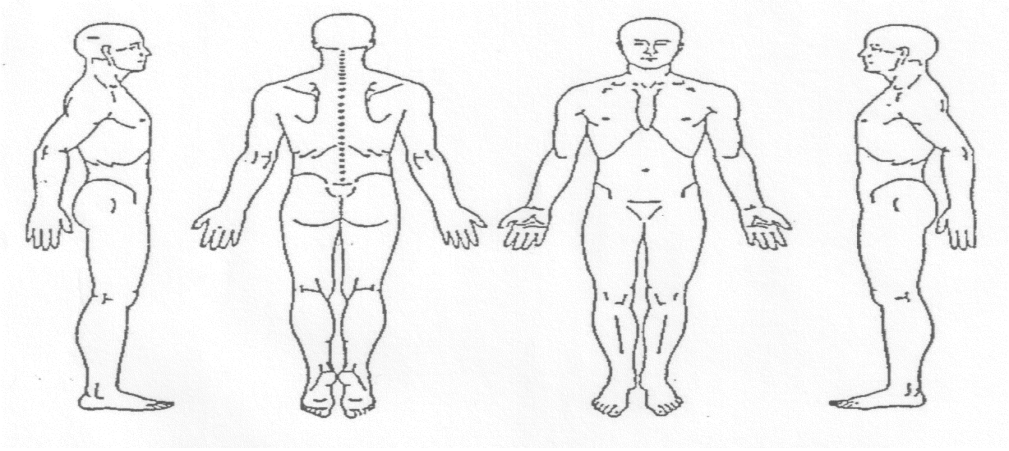
How much **water** do you drink per day? _____

How much **caffeinated coffee, tea, or cola** do you drink per day? _____

How many **alcoholic beverages** do you drink per day? _____

Do you **smoke**? If yes, how many cigarettes or cigars per day? _____

PLEASE INDICATE ANY PAINFUL OR DISTRESSE AREA



PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

If you have ever had any of the symptom below, write "P", if they occurred in the past, "C" if current , and "I" if they are intermittent.

GENERAL

☐ Poor Sleeping	☐ Night Sweats	☐ Fever	☐ Chills
☐ Sweat Easily	☐ Cravings	☐ Change in Appetite	☐ Peculiar Taste or Smell
☐ Weight Loss	☐ Weight Gain	☐ Bleed or Bruise Easily	☐ Fatigue
☐ Strong Thirst (for hot or cold drinks)		☐ Sudden Energy Drop (what time of day?)_____	

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SKIN & HAIR

- ☐ Rashes
- ☐ Ulceration
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Change in Hair or Skin Texture
- ☐ Other Problem

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Eye Tearing
- ☐ Eye Strain/Pain
- ☐ Poor Vision
- ☐ Blurry Vision
- ☐ Spots in front of Eyes
- ☐ Cataracts
- ☐ Earaches
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Sinus Problems
- ☐ Nose Bleed
- ☐ Recurrent Sore Throat
- ☐ Grinding Teeth
- ☐ Facial Pain
- ☐ Headache (where, when?) _____
- ☐ Teeth problem
- ☐ Jaw Clicks
- ☐ Sores on Lips or Tongue
- ☐ Other Problem

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Swelling of Hands
- ☐ Fainting
- ☐ Cold Hands and Feet
- ☐ Phlebitis
- ☐ Swelling of Feet
- ☐ Blood Clots
- ☐ Other Heart Problem

RESPIRATORY

- ☐ Cough
- ☐ Coughing Blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with a Deep Breath
- ☐ Difficulty in Breathing
- ☐ Phlegm Production
- ☐ Other Lung Problem

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black Stool
- ☐ Blood in Stools
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal Pain or Cramps
- ☐ Chronic Laxative Use
- ☐ Poor appetite
- ☐ Other Stomach or Intestine Problem

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GENITO-URINARY

☐ Frequent Urination ☐ Pain upon Urination ☐ Blood in Urine ☐ Urgency to Urinate
☐ Unable to Hold Urine ☐ Kidney Stones ☐ Decrease in Urine Flow ☐ Impotence
☐ Sore on Genitals ☐ Wake up to Urinate (how often?) _____ ☐ Other Problem

MUSCULOSKELETAL

☐ Neck Pain ☐ Muscle Pain ☐ Knee Pain ☐ Back Pain
☐ Muscle Weakness ☐ Foot/Ankle Pain ☐ Hand/Wrist Pain ☐ Shoulder Pain
☐ Hip Pain ☐ Other Joint and Bone Problem

REPRODUCTIVE AND GYNECOLOGIC

# of Pregnancies____ # of Live Birth_____ # of Premature Birth____ # of Miscarriage____
# of Abortion_____ ☐ Vaginal Discharge ☐ Menstrual Clots ☐ Breast Lumps
☐ Unusual Periods (heavy, light, etc.) ☐ Spotting or Pain between Periods
☐ Menstrual Pain ☐ Irregular Periods ☐ Menopause (age_☐ Age of 1st Menses____
Date of Last Period_____ # of Days Period Lasts _____ #of Days between Periods_____
Date of Last Pap _____ Results_____
Do you notice any change in body/psyche prior to period?_____
Do you practice birth control? What type and for how long?_____
Is there any chance that you are pregnant now?_____

NEUROPSYCHOLOGICAL

☐ Nausea ☐ Lack of Coordination ☐ Loss of Balance ☐ Areas of Numbness
☐ Depression ☐ Poor Memory ☐ Concussion ☐ Anxiety
☐ Easily Susceptible to Stress ☐ Bad Temper ☐ Tremors

Have you ever been treated for emotional problem? (when? What?)_____
Have you ever considered or attempted suicide?_____
Any other neurological or psychological problem? _____

COMMENTS

Please write down any other problems you would like to discuss, which is not asked on this form

_____

_____