Olympic Acupuncture & Natural Wellness Clinic

HEALTH HISTORY QUESTIONNAIRE

This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released without your written authorization.

Please take the time to fill out this questionnaire carefully. If you have questions, please ask for help. The completed form will greatly assist in a complete evaluation of your health. *You should eat within 3 hours prior to acupuncture. No alcohol within 12 hours of treatment. If you take prescription medications, do not change your schedule or dose.*

Personal History

Date: Cell Phone

Address City State Zip Code

Email:

Age Height Weight Date of Birth:

Living Situation (Married, Domestic Partnership, Single, Divorced, Widowed)

Occupation: Employer Name

Family Physician:

In case of emergency notify Relation Phone

How did you find us? (e.g. word of mouth, newspaper, radio, etc.)

Yes	No		Yes	No	
☐	☐	Have you tried acupuncture before?	☐	☐	Do you have hepatitis or HIV?
☐	☐	Are you nervous about needles?	☐	☐	Have you ever had hepatitis?
☐	☐	Do you have a tendency to faint?	☐	☐	Do you have a pacemaker?
☐	☐	Do you bleed or bruise easily?	☐	☐	Women: Are you pregnant?

Present Health

Major Complaint(s):

Date of onset (when you first noticed your problem)

Is there pain? No ☐ Yes ☐ If yes, please rate 1 (Minimal) to 10 (Unbearable)

Is your condition: Getting worse ☐ Constant ☐ Comes and Goes ☐

Have you been given a diagnosis for your problem? No ☐ Yes ☐ If yes, what, when, and by whom?

What kinds of treatments have you tried?

Past Medical History

List **all** illnesses or diseases for which you have received medical care and a diagnosis for (include approx. dates):

List all surgeries (include approx. dates):

List **all** medications and supplements that you are currently taking:

Review of Systems

*Please check any that you are experiencing **now or in the last three months***

Skin and Hair:	Cardiovascular:	Gastrointestinal:
❑ Eczema/Psoriasis	❑ High / Low blood pressure	❑ Nausea / Vomiting
❑ Dry / Oily / Itchy	❑ Irregular heartbeat	❑ Poor appetite
❑ Moles / Lumps	❑ Chest pain / pressure	❑ Belching / Indigestion
❑ Rashes / Hives	❑ Blood clots	❑ Bad breath
❑ Bruise easily	❑ Cold hands / feet	❑ Abdominal pain / Cramps
❑ Hair loss	❑ Swelling hands / feet	❑ Flatulence / Gas
❑ Sores / Ulcers	❑ Dizziness / Vertigo	❑ Diarrhea / Constipation
❑ Other:	❑ Varicose veins	❑ Hemorrhoids / Rectal pain
	❑ Pain or cramping in legs	❑ Blood in stool / Black stool
	❑ Heart disease	❑ Laxative use
	❑ Other heart or blood vessel problems	❑ Occasionally/frequently skip meals
		❑ Currently overweight
Head, Ears, Eyes, Nose, Throat:		❑ Crave sweets or carbohydrates
❑ Headaches / Migraines		❑ Crave stimulants, such as caffeine or soft drinks
❑ Facial pain	Genito-Urinary:	
❑ Ringing in ears	❑ Painful urination	❑ Other digestive problems:
❑ Earaches / Poor hearing	❑ Urgency to urinate	
❑ Jaw clicks, teeth grinding	❑ Frequent urination	
❑ Teeth, gum problems	❑ Difficulty urinating	
❑ Cataracts / Glaucoma	❑ Decrease in flow / stream	Respiratory:
❑ Poor vision / eye pain	❑ Incontinence	❑ Recurring cough
❑ Spots in front of eyes	❑ Scanty dark urine	❑ Asthma / Bronchitis
❑ Color / Night blindness	❑ Kidney stones	❑ Shortness of breath/tight chest
❑ Nose bleeds	❑ Venereal disease	❑ Coughing up blood
❑ Nasal stuffiness	❑ Wake at night to urinate	❑ Pain with deep inhalation
❑ Constant head colds	How often?	❑ Pneumonia
❑ Loss of smell	❑ Men: Last prostate exam:	❑ Production of phlegm? What color?
❑ Sores on lips or tongue	❑ Impotence	
❑ Recurrent sore throats	❑ Other genital or urinary	❑ Difficulty breathing lying down
❑ Other Head or Neck Problems:	problems:	❑ Other lung problems:

Review of Systems, con't.

Musculoskeletal:

- ❑ Joint pain / stiffness
- ❑ Muscle pain
- ❑ Numbness / tingling
- ❑ Neck pain
- ❑ Back pain
- ❑ Shoulder pain
- ❑ Hand / wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot / ankle pain
- ❑ Other musculoskeletal problems:

Neuropsychological:

- ❑ Frequent headaches
- ❑ Poor memory
- ❑ Seizures
- ❑ Depression
- ❑ Fear / anxiety
- ❑ Mood swings
- ❑ Bad temper
- ❑ Crying spells
- ❑ Overwhelming joy
- ❑ Concussion
- ❑ Poor coordination
- ❑ Easily susceptible to stress

What is the level of stress you are currently experiencing on a scale of 1 to 10 (1 being the lowest) _____

- ❑ Received treatment for emotional problems
- ❑ Considered or attempted suicide
- ❑ Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents?
- ❑ Other neurological or psychological problems:

Reproductive and Gynecologic:

- ❑ Pregnancies:
- ❑ Births:
- ❑ Premature/Miscarry:
- ❑ Stillborn/Abortions:
- ❑ First menses:
- ❑ Days between menses:
- ❑ Duration:
- ❑ Date of last menses:
- ❑ Regular ❑ Irregular

Clots: ❑ No ❑ Yes

Blood: ❑ Dark ❑ Med. ❑ Light

Flow: ❑ Excess ❑ Norm ❑ Spot

- ❑ Pain with menses

Last Pap:

- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Breast lumps
- ❑ Nipple discharge
- ❑ Birth control Type: _____
- ❑ Other reproductive or gynecologic problems:

General:

- ❑ Fatigue
- ❑ Poor appetite
- ❑ Insomnia / Sleep disorders
- ❑ Disturbed sleep
- ❑ Localized weakness
- ❑ Strong thirst
- ❑ Weight gain/loss (10% or more in 6 months)
- ❑ Sweating easily
- ❑ Tremors
- ❑ Bleeding or bruising easily
- ❑ Night sweats
- ❑ Fever
- ❑ Chills
- ❑ Sudden energy drop

Time of day: _____

- ❑ Poor balance
- ❑ Other unusual or abnormal conditions you have noticed in your general sense of health:

Appetite / Food:

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Changes in appetite
- ❑ Cravings
- ❑ Water 8oz glasses/day _____
- ❑ Alcohol _____
- ❑ Caffeine:

Coffee: # 6oz cups/day _____

Tea: # 6oz cups/day _____

Soda w/caffeine: # cans/day _____

Soda w/o caffeine: # cans/day _____

Other sources: _____

- ❑ Specific food restrictions of:
  - ❑ Dairy ❑ Wheat ❑ Eggs
  - ❑ Soy ❑ Corn ❑ Gluten
  - ❑ Other

Please describe any other issues that are concerns for you: