Dear

Thank you for choosing The Acupuncture & Herbal Center. Please fill out the health history questionnaire completely and bring it with you for your first treatment. Your appointment is _____. If you need to change this appointment for any reason, we kindly ask for 24 hours notice. I look forward to seeing you.

Sincerely,
Brian Whidden
Licensed Acupuncturist

HEALTH HISTORY QUESTIONNAIRE

Name:	**Day Phone:**	**Evening Phone:**
Street	**Town**	**Zip**
D.O.B.	**E-Mail**	
Marital Status:	**Height**	**Weight**
In case of an emergency, please notify:		**Telephone#:**
Social Security	**Family Physician:**	
Insurance Company	**Policy Number:**	**Subscriber:**
Referred by:		

Have you ever been treated with Acupuncture or Oriental Medicine before? If so, where and when?

_____

_____

Have you had any other type of alternative therapy in the last year (Chiropractic, Massage, etc.)? If so, where and when?_____

_____

Main Complaint(s) List in order of priority and include date problem began:

#1_____

#2_____

#3_____

#4_____

#5_____

Any other issues:_____

_____

Family Medical History: Diabetes, Cancer, High Blood Pressure, Heart Disease, Stroke, Seizures Asthma Allergies, etc. _____

_____

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

_____

_____

Occupation _____ Occupational Stress (chemical, physical, psychological)

_____

_____

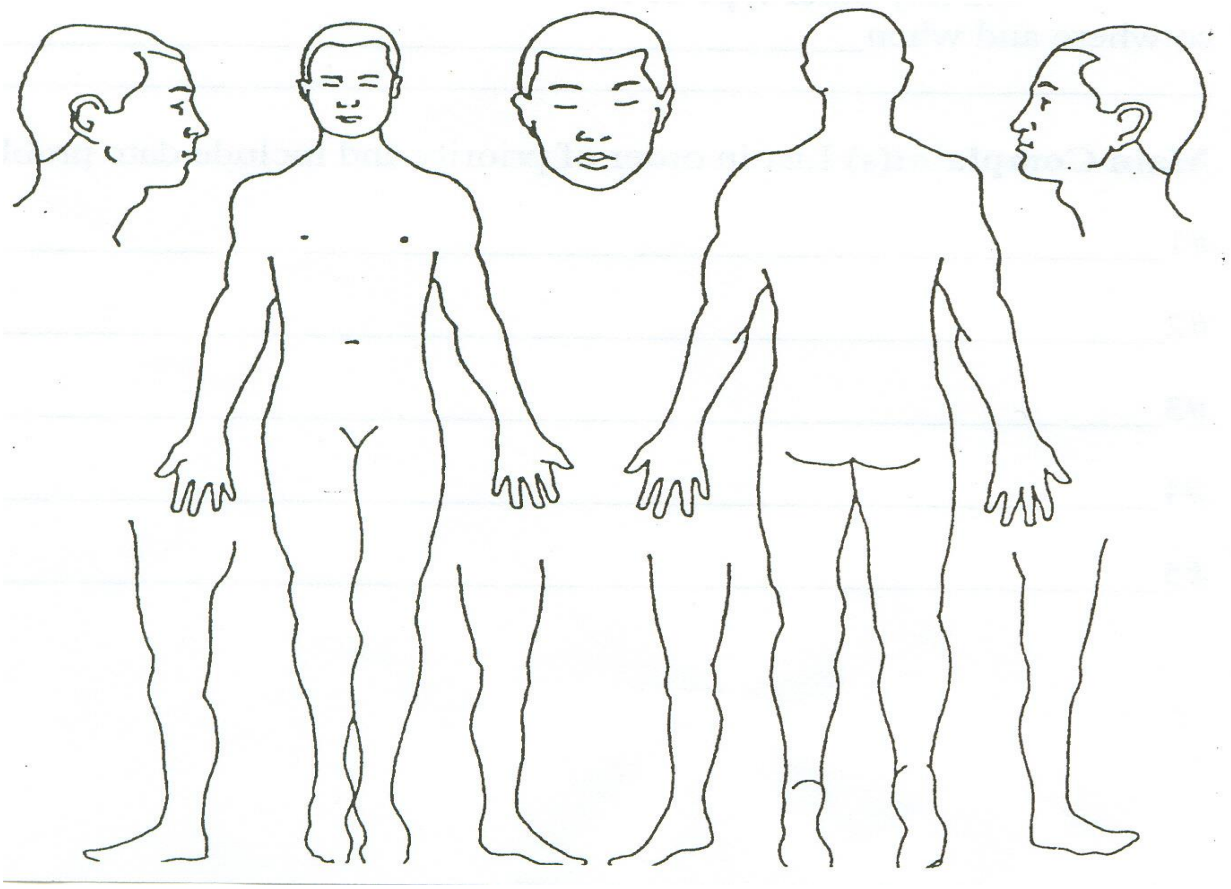
Do you have a regular exercise program? _____ Please describe_____

_____

_____

Have you ever been on a restricted diet?_____ What kind?___ _____

Indicate painful or distressed areas:



Please check if you have had (in the last three months):

GENERAL:

☐ Poor Appetite	☐ Poor sleeping	☐ Fatigue
☐ Fevers	☐ Chills	☐ Night sweats
☐ Sweat easily	☐ Tremors	☐ Cravings
☐ Localized weakness	☐ Poor balance	☐ Change in appetite
☐ Bleed or bruise easily	☐ Weight loss	☐ Weight gain
☐ Peculiar tastes or smells	☐ Strong thirst (cold or hot drinks)	☐ Sudden energy drop (What time of day?)

MUSKULOSKELETAL:

☐ Neck pain	☐ Muscle pains	☐ Knee pain
☐ Back pain	☐ Muscle weakness	☐ Foot/ankle pain
☐ Hand/wrist pains	☐ Shoulder pain	☐ Hip pain

Any other joint or bone problems?_____

_____

REPRODUCTIVE AND GYNECOLOGIC:

____ Number of pregnancies	____ Number of Births	____ Premature births
____ Number of miscarriages	____ Abortions	____ Age at first menses
____ Days between menses	____ Duration	

_____ 1st day of last menses _____ date of last PAP smear

☐ Unusual character (heavy/light)	☐ Irregular	☐ Clots
☐ Painful periods	☐ Vaginal sores	☐ Breast lumps
☐ Vaginal discharge	☐ Menopause (Age _____)	

☐ Changes in body/psyche prior to menstruation

Do you practice birth control?_____ What type and for how long? _____

RESPIRATORY:

☐ Cough	☐ Cough blood	☐ Asthma
☐ Bronchitis	☐ Pneumonia	☐ Pain with deep breath
☐ Difficulty breathing when lying down	☐ Production of phlegm (what color)?_____	

Any other lung problems?_____

CARDIOVASCULAR

☐ High Blood Pressure	☐ Low Blood Pressure	☐ Chest pain
☐ Irregular heart beat	☐ Dizziness	☐ Fainting
☐ Cold hands or feet	☐ Swelling of hands	☐ Swelling of Feet
☐ Blood clots		

Any other heart or blood vessel problems? _____

GASTROINTESTINAL

☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Constipation	☐ Gas	☐ Belching
☐ Black stools	☐ Blood in stools	☐ Indigestion
☐ Bad breath	☐ Rectal Pain	☐ Hemorrhoids
☐ Abdominal pain or cramps	☐ Chronic laxative use	

Any other problems with your stomach or intestines? _____

GENITO-URINARY

☐ Pain on urination	☐ Frequent urination	☐ Blood in urine
☐ Urgency to urinate	☐ Unable to hold urine	☐ Kidney Stones
☐ Decrease in flow	☐ Impotency	☐ Sores on genitals

Do you wake up to urinate? _____ How often? _____

Any particular color to your urine (if yes, please describe)? _____

Any other problems with your genital or urinary system? _____

HEAD, EYES, EARS, NOSE AND THROAT

☐ Dizziness	☐ Concussions	☐ Migraines
☐ Glasses	☐ Eye strain	☐ Eye pain
☐ Poor vision	☐ Night blindness	☐ Color blindness
☐ Cataracts	☐ Blurry vision	☐ Earaches
☐ Ringing in ears	☐ Poor hearing	☐ Spots in front of eyes
☐ Sinus problems	☐ Nose bleeds	☐ Recurrent sore throat
☐ Grinding teeth	☐ Facial pain	☐ Sores on lips/tongue
☐ Teeth problems	☐ Jaw clicks	

☐ Headaches, where and when? _____

Any other head or neck problems? _____

SKIN AND HAIR

☐ Rashes	☐ Ulcerations	☐ Hives
☐ Itching	☐ Eczema	☐ Pimples
☐ Dandruff	☐ Loss of hair	☐ Recent moles
☐ Change in hair or skin texture	Any other hair or skin problems? _____	

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Dizziness	☐ Loss of balance
☐ Area of numbness	☐ Lack of coordination	☐ Poor memory
☐ Concussion	☐ Depression	☐ Anxiety
☐ Bad Temper	☐ Easily susceptible to stress	

Have you ever been treated for emotional problems? _____

Have you ever considered to attempted suicide? _____

Any other neurological or psychological problems? _____

COMMENTS:_____

_____