HEALTH HISTORY QUESTIONNAIRE
Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. General Patient Information

Date: ____/____/____

Name: ____________________

Address: ____________________

City, State, Zip Code: ____________________

Home Phone: (______)____________________ Work Phone: (______)____________________

Cell Phone : (_______)____________________ Email: ____________________

Age: ______ Date of Birth: ____/____/____ Gender: ☐M ☐F Height: ____'____" Weight: ______lbs.

Guardian (if under 18): ____________________

Emergency Contact – Name: ____________________ Phone: (______)____________________

Your Occupation:____________________Employer:____________________

How did you hear about our office? ____________________

Major Complaint(s), in order of significance to you:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Additional:____________________

How do these conditions impair your daily activities ____________________

____

Please list all of the prescription medications that you are currently taking:
1.
2.
3.
4.

Please list all of the vitamins, herbs, and nutritional supplements that you are currently taking:
1.
2.
3.
4.

II. Patient Medical History

How was your childhood health?______________________________

Hospital Visits/Stays:______________________________

Recent tests: (please indicate test results and date below)

☐Physical ☐Cholesterol ☐Prostate ☐Blood (which?)
☐HIV ☐Pap smear ☐Mammography ☐Other:__________
☐STD

Test Results and Date:______________________________

Check any you have had in the past:

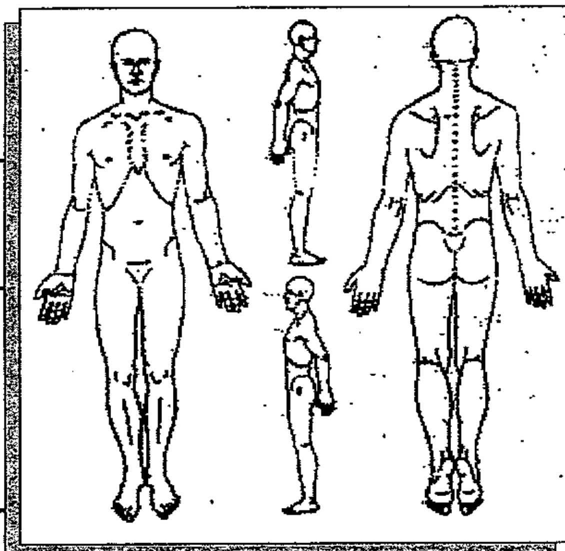
☐Diabetes ☐Allergies ☐Glaucoma ☐Rheumatic Fever
☐Heart Disease ☐CVA (stroke) ☐Vein condition ☐Thyroid disorder
☐Asthma ☐Pneumonia ☐Tuberculosis ☐Emphysema
☐Jaundice ☐Gonorrhea ☐Mumps ☐Bleeding tendency
☐Syphilis ☐Measles ☐Chicken pox ☐Nervous disorder
☐Meningitis ☐HIV ☐Polio ☐Mononucleosis
☐Epilepsy ☐High fever ☐Hepatitis ☐Multiple Sclerosis
☐Paralysis ☐Cancer ☐Migraines ☐High blood pressure
☐other lung illnesses ☐other liver illnesses ☐other heart illnesses ☐other kidney illnesses
☐other:____________________

Immunizations:______________________________

Surgeries:______________________________

III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the pain:

☐Sharp ☐Burning ☐Aching
☐Cramping ☐Dull ☐Moving
☐Fixed ☐Other:__________

Do the following lessen the pain?

☐Pressure ☐Cold ☐Heat
☐Exercise ☐Other:__________

Do the following worsen the pain?

☐Pressure ☐Cold ☐Heat
☐Exercise ☐Other:__________

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

☐Cold hands
☐Cold fingers
☐Cold feet
☐Cold toes
☐Sweaty hands
☐Sweaty feet
☐Hot body temperature (sensation)
☐Cold body temperature (sensation)
☐Afternoon flushes
☐Night sweats
☐Heat in the hands, feet, and chest
☐Hot flashes any time of the day
☐Thirsty
☐Perspire easily
☐Lack of perspiration
☐Take water to bed

Overall energy (Lung, Kidney function):

☐Shortness of breath
☐Difficulty keeping eyes open in the daytime
☐General weakness
☐Easily catch colds
☐Low energy
☐Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):

☐Dizziness
☐See floating black spots

Heart function:

☐Palpitations
☐Anxiety
☐Sores on the tip of the tongue
☐Restlessness
☐Mental confusion
☐Chest pain traveling to shoulder
☐Frequent dreams
☐Wake unrefreshed
☐Drink coffee (# of cups per week: _______)

Lung function:

☐Nasal Discharge (Color: __________________)
☐Cough
☐Nose Bleeds
☐Sinus Congestion
☐Dry mouth
☐Dry throat
☐Dry Nose
☐Dry Skin
☐Allergies (To what? ______________________________)
☐Alternating fever and chills

☐Sneezing
☐Headache (Location: ______________________________)
☐Overall achy feeling in the body
☐Stiff neck
☐Stiff shoulders
☐Sore throat
☐Difficulty breathing
☐Smoke cigarettes (# of cigarettes per day: _______)
☐Sadness
☐Melancholy

Spleen function:
☐Low appetite
☐Abrupt weight gain
☐Abrupt weight loss
☐Abdominal bloating
☐Abdominal gas
☐Gurgling noise in the stomach
☐Fatigue after eating
☐Prolapsed organs (previously diagnosed, which organ? ________________)
☐Easily bruised
☐Hemorrhoids
☐Over-thinking
☐Worry

Spleen, Stomach, Large Intestine, Small Intestine function:
☐Loose
☐Constipated
☐Incomplete
☐Diarrhea
☐Blood in stools
☐Mucous in stools
☐Undigested food in stools

Dampness trapped in the body:
☐General sensation of heaviness in the body
☐Mental sluggishness
☐Loss of mental clarity
☐Swollen hands
☐Swollen feet
☐Swollen joints
☐Chest congestion
☐Nausea
☐Snoring

Stomach function:
☐Burning sensation after eating
☐Large appetite
☐Bad breath
☐Mouth (canker) sores
☐Bleeding, swollen or painful gums
☐Heartburn
☐Acid regurgitation
☐Ulcer (diagnosed)
☐Belching
☐Hiccoughs
☐Stomach pain
☐Vomiting

Liver, Gall Bladder function:

- ☐Alternating diarrhea and constipation
- ☐Chest pain
- ☐Tight sensation in the chest
- ☐Bitter taste in the mouth
- ☐Anger easily
- ☐Depression
- ☐Irritability
- ☐Frequently unable to adapt to stress (What causes the stress? ________________________)
- ☐Skin rashes
- ☐Acne
- ☐Headache at the top of the head
- ☐Tingling sensation
- ☐Numbness
- ☐Muscle spasms
- ☐Muscle twitching
- ☐Muscle cramping
- ☐Seizures
- ☐Convulsions
- ☐Lump in the throat
- ☐Drink alcohol
- ☐Recreational drugs (Which? ______________, How much per week? ______)
- ☐High-pitched ringing in the ears
- ☐Gall stones (history or current)
- ☐Sexually transmitted disease (Which? ______________)

Eyes (Liver function):

- ☐Itchy
- ☐Bloodshot
- ☐Hot
- ☐Dry
- ☐Watery
- ☐Gritty
- ☐Blurry vision
- ☐Decreased night vision
- ☐Near-sighted
- ☐Far-sighted

Kidney, Urinary Bladder function:

- ☐Frequent cavities
- ☐Easily broken bones
- ☐Sore knees
- ☐Weak knees
- ☐Cold sensation in the knees
- ☐Low back pain
- ☐Memory problems
- ☐Excessive hair loss
- ☐Low-pitched ringing in the ears
- ☐Kidney stones
- ☐Bladder infections
- ☐Wake during the night twice or more to urinate
- ☐Lack of bladder control
- ☐Fear
- ☐Easily startled

Name Date

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age ________ How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Main reason for today's visit: ____________________

Other concerns: ____________________

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
____ Recent fevers/sweats
____ Unexplained weight loss/gain
____ Unexplained fatigue/weakness

Eyes
____ Change in vision

Ears/Nose/Throat/Mouth
____ Difficulty hearing/ringing in ears
____ Hay fever/allergies/congestion
____ Trouble swallowing

Cardiovascular
____ Chest pains/discomfort
____ Palpitations
____ Short of breath with exertion

Breast
____ Breast lump
____ Nipple discharge

Respiratory
____ Cough/wheeze
____ Coughing up blood

Gastrointestinal
____ Heartburn/reflux
____ Blood or change in bowel movement
____ Nausea/vomiting/diarrhea
____ Pain in abdomen

Genitourinary
____ Painful/bloody urination
____ Leaking urine
____ Nighttime urination
____ Discharge: penis or vagina
____ Unusual vaginal bleeding
____ Concern with sexual functions

Musculoskeletal
____ Muscle/joint pain
____ Recent back pain

Skin
____ Rash
____ New or change in mole

Neurological
____ Headaches
____ Memory loss
____ Fainting

Psychiatric
____ Anxiety/stress
____ Sleep problem

Blood/Lymphatic
____ Unexplained lumps
____ Easy bruising/bleeding

Endo
____ Cold/heat intolerance
____ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ❑ Yes ❑ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day

Allergies or reactions to medications: ____________________

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A ______ Hepatitis B ______ Influenza (flu shot) ______ MMR ______ Pneumovax (pneumonia) ______

Meningitis ______ Tetanus (Td) ______ Varicella (chicken pox) shot or Illness ______ Tdap (tetanus & pertussis) ______

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) ____________ Date ________ Abnormal? ❑ Yes ❑ No

Sigmoidoscopy _____ or *Colonoscopy* ________ Date ________ Abnormal? ❑ Yes ❑ No

Women: *Mammogram* ______ Date ______ Abnormal? ❑ Yes ❑ No *Pap Smear* _____ Date _____ Abnormal? ❑Yes ❑No

Dexascan (osteporosis) _____ Date ______ Abnormal? ❑ Yes ❑ No

Men: *PSA* (prostate) ____________ Date ________ Abnormal? ❑ Yes ❑ No

– OVER –

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

____ Heart disease:
specify type ____________________
____ Asthma/Lung disease

____ High blood pressure
____ Diabetes
____ Other: (specify): ______________

____ High cholesterol
____ Thyroid problem
____ Kidney disease
____ Cancer: (specify): ______________

SURGICAL HISTORY: Please list all prior operations (with dates):

____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism ____________________
Cancer, specify type ____________________
Heart disease ____________________
Depression/suicide ____________________
Genetic disorders ____________________
Diabetes ____________________

High cholesterol ____________________
High blood pressure ____________________
Stroke ____________________
Bleeding or clotting disorder ____________________
Asthma/COPD ____________________
Other: ____________________

SOCIAL HISTORY

Tobacco Use

Cigarettes ❑ Never ❑ Quit Date ______________
❑ Current Smoker: packs/day ________ # of yrs ________
Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew
Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes # drinks/week ________
Is your alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use

Do you use any recreational drugs? ❑ No ❑ Yes
Have you ever used needles to inject drugs? ❑ No ❑ Yes

Sexual Activity

Sexually active: ❑ Yes ❑ No ❑ Not currently
Current sex partner(s) is/are: ❑ male ❑ female
Birth control method: ______________ ❑ None needed
Have you ever had any sexually transmitted diseases (STDs)?
❑ No ❑ Yes
Are you interested in being screened for sexually transmitted diseases? ❑ No ❑ Yes

OTHER CONCERNS

Caffeine Intake: ❑ None ❑ Coffee/tea/soda ____ cups/day
Weight: Are you satisfied with your weight? ❑ No ❑ Yes
Diet: How do you rate your diet? ❑ Good ❑ Fair ❑ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ❑ No ❑ Yes
Exercise: Do you exercise regularly? ❑ No ❑ Yes
What kind of exercise? ______________
How long (minutes) ________ How often? ________
If you do not exercise, why? ______________
Safety: Do you use a bike helmet? ❑ No ❑ Yes ❑ NA
Do you use seatbelts consistently? ❑ No ❑ Yes
Is violence at home a concern for you? ❑ Yes ❑ No
Have you ever been abused? ❑ Yes ❑ No
Do you have a gun in your home? ❑ Yes ❑ No

Have you completed a living will or or durable power of attorney for health care? ❑ Yes ❑ No

SOCIOECONOMICS Occupation: ______________ Employer: ______________
Years of education/highest degree: ______ Marital Status: Single Partner/Married Divorced Widowed Other: ________
Spouse/partner's name: ______________ Number of children/ages: ______________
Who lives at home with you? ______________

WOMEN'S HEALTH HISTORY # pregnancies ______ # deliveries ______ # abortions ______ # miscarriages ______
Age at start of periods: ________ Age at end of periods: ________

– OVER –

Financial Agreement

Please read this agreement carefully.
We will be happy to answer any questions you may have.

I, ______________________________ (client), understand that my insurance is an agreement between the insurance company and myself.

I understand that ____________________________ (health care provider), will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied by my insurance company.

I assign payments to be made on my behalf to this provider for any services furnished to me. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

If the bills for services are not paid within sixty (60) days by my insurance carrier, I am responsible for the balance on the sixty-first (61st) day.

In the event my insurance company does not pay in full for services provided, I hereby authorize the health care provider to charge all past due payments to my credit card listed below.

In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I ____________________________ (client), will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I have read and understand this financial agreement.

Signature: ____ Date: ____________________

Credit Card Number: ______________________________________ Expiration Date: __________

Name of Cardholder as it Appears on Credit Card: ____

Privacy Policies Notice

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard the information included in your files. We have installed a firewall on our computer; computerized files can only be accessed with a password; and all paperwork is kept in a locked filing cabinet.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.

Your Personal and Protected Health Information

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

* We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
* We may disclose your PHI to any third party you designate in writing.
* We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
* We may disclose your PHI if we ever sell or transfer our practice.
* We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
* We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
* We may disclose your PHI to a health oversight agency for activities authorized by law.
* We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
* We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
* We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
* Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
* We may use or disclose your PHI when required by law.
* We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to our Privacy Officer at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

Original Effective Date: April 14, 2003

This notice remains in effect until it is replaced or amended by changes in the law.

X ______
Initial