West Seattle Acupuncture

Health History Questionnaire

Date: ____ /_____ /_____

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be kept absolutely confidential. If you have any questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the Comments Section on page 4. Thank you.

Name:				
Address:		**City:**	**State:**	**Zip:**
Home Phone: ( )	**Work Phone:** ( )		**Sex:** ( ) Male ( ) Female	**Age:**
Date of Birth: / /	**City of Birth:**		**State of Birth:**	
Height:	**Weight:**	**Employer Name:**		
Occupation:	**Family Physician:**			
Emergency Contact:	**Emergency Contact Phone:** ( )		Have you been treated by acupuncture or oriental medicine before? O Yes O No	

What is/are the main problem(s) you would like us to help you with?: _____

_____

_____

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

_____

_____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?: _____

_____

_____

Have you been given a diagnosis for this problem? If so, what?: _____

_____

_____

What kinds of treatment have you tried?: _____

_____

_____

Past Medical History:
(please include dates)

Cancer _____ High Blood Pressure _____ Thyroid Disease _____

Diabetes _____ Heart Disease _____ Seizures _____

Hepatitis _____ Rheumatic Fever _____ Venereal Disease _____

Other _____

Significant Trauma (auto accidents, falls, etc): _____

_____

_____

Significant Dental Work (type and date): _____

_____

_____

Birth History (prolonged labor, forceps delivery, etc.): _____

_____

_____

Allergies (drugs, chemicals, foods/result): _____

_____

_____

Family Medical History:	O Diabetes	O High Blood Pressure	O Stroke	O Asthma
(check)	O Cancer	O Heart Disease	O Seizures	O Allergies
	O Other _____			

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

_____

_____

Occupational Stress (chemical, physical, psychological, etc): _____

_____

_____

Do you have a regular exercise program? O Yes O No Please describe: _____

_____

_____

Have you ever been on a restricted diet? O Yes O No Please describe: _____

_____

_____

Please Describe Your Average Daily Diet

Morning _____

Afternoon _____

Evening _____

How many packs of cigarettes do you smoke per day? _____

How much alcohol do you drink per week? _____

How much coffee, tea or cola do you drink per week? _____

Please describe and use of drugs for non-medical purposes ___

_____

Please Check Any Symptoms You Have Had in the Last Three Months

General

O Chills
O Fevers
O Sweat Easily
O Night Sweats
O Localized weakness
O Bleed or bruise easily
O Peculiar tastes of smells
O Strong thirst (cold or hot)
O Thirst, no desire to drink
O Fatigue
O Sudden energy drop
Time of day? _____
O Edema
Where? _____
O Poor sleeping
O Tremors
O Poor Balance
O Cravings
O Change in appetite
O Poor appetite
O Weight gain
O Weight loss

Skin And Hair

O Rashes
O Itching
O Change in hair or skin
O Ulcerations
O Eczema
O Oozing on skin lesion
O Hives
O Pimples
O Recent Moles
O Loss of Hair
O Dandruff
Other hair or skin problems: _____
_____

Head, Eyes, Ears, Nose & Throat

O Dizziness
O Migraines
O Headaches
When? _____
Where? _____
O Facial pain
O Glasses
O Poor vision
O Night blindness
O Blurry vision
O Color blindness
O Blind field
O Spots in front of eyes
O Eye pain
O Eye strain
O Cataracts
O Eye dryness
O Excessive tear
O Discharge from eyes
O Poor hearing
O Ringing in ears
O Earaches
O Discharge from ear
O Nose bleeds
O Sinus congestion
O Nasal drainage
O Grinding teeth
O Teeth problems
O Jaw clicks
O Concussions
O Recurrent sore throats
O Hoarseness
O Sores on lips or tongue
Other head or neck problems: _____
_____

Cardiovascular

O High blood pressure
O Low blood pressure
O Chest discomfort/pain
O Heart palpitations
O Cold hands or feet
O Swelling of hands
O Swelling of feet
O Blood clots
O Fainting
O Difficulty in breathing
Other heart or blood vessel problems: _____
_____

Respiratory

O Cough
O Asthma/wheezing
O Pain with a deep breath
O Difficulty in breathing when lying down
O Production of phlegm
What color? _____
O Coughing blood
O Pneumonia
O Bronchitis
Other lung problems: _____
_____

Gastrointestinal

O Bad breath
O Nausea
O Vomiting
O Heartburn
O Belching
O Indigestion
O Diarrhea
O Constipation
O Chronic laxitive use
O Blood in stool
O Black stools

Gastrointestinal (cont)

O Abdominal pain or cramps
O Gas
O Rectal pain
O Hemorrhoids
Other stomach or intestinal problems:
_____
_____

Genito-Urinary

O Pain on urination
O Urgency to urinate
O Frequent Urination
O Blood in urine
O Decrease in flow
O Unable to hold urine
O Dribbling
O Kidney stones
O Impotency
O Change of sexual drive
O Sores on genitals
Do you wake up to urinate?
O Yes O No
How often?
_____
Any particular color to your urine?
_____
Other genital or urinary system problems:
_____
_____

Pregnancy & Gynecology

Number of pregnancies: _____
Number of births: _____
Number of premature births: _____
Number of miscarriages: _____
Number of abortions: _____
Age at first menses: _____
Period between menses (days): _____
Duration of menses (days): _____
First date of last menses:
_____ /_____ /_____
O Heavy periods
O Painful periods
O Irregular periods
O Changes in body/psyche prior to menstruation
O Clots
O Menopause:
Age _____
Year _____
O Vaginal discharge
O Postcoital bleeding
O Vaginal sores
Date of last pap: ____ /____ /____
O Breast lumps
O Nipple discharge
Do you practice birth control?
O Yes O No
What type and for how long?
_____
_____

Musculoskeletal

O Neck pain
O Shoulder pain
O Back pain
O Elbow pain
O Hand/wrist pain
O Hip pain
O Knee pain
O Foot/ankle pain
O Muscle pain
O Muscle weakness

Neuropsychological

O Seizures
O Areas of numbness
O Weakness
O Sleep disorder
O Concussion
O Bad temper
O Loss of control/violence potential
O Vertigo
O Lack of coordination
O Depression
O Easily susceptible to stress
O Loss of balance
O Poor memory
O Anxiety
O Substance abuse
Have you ever been treated for emotional problems? O Yes O No
Have you ever considered or attempted suicide?
O Yes O No
Other neurological or psychological problems: __
_____
_____

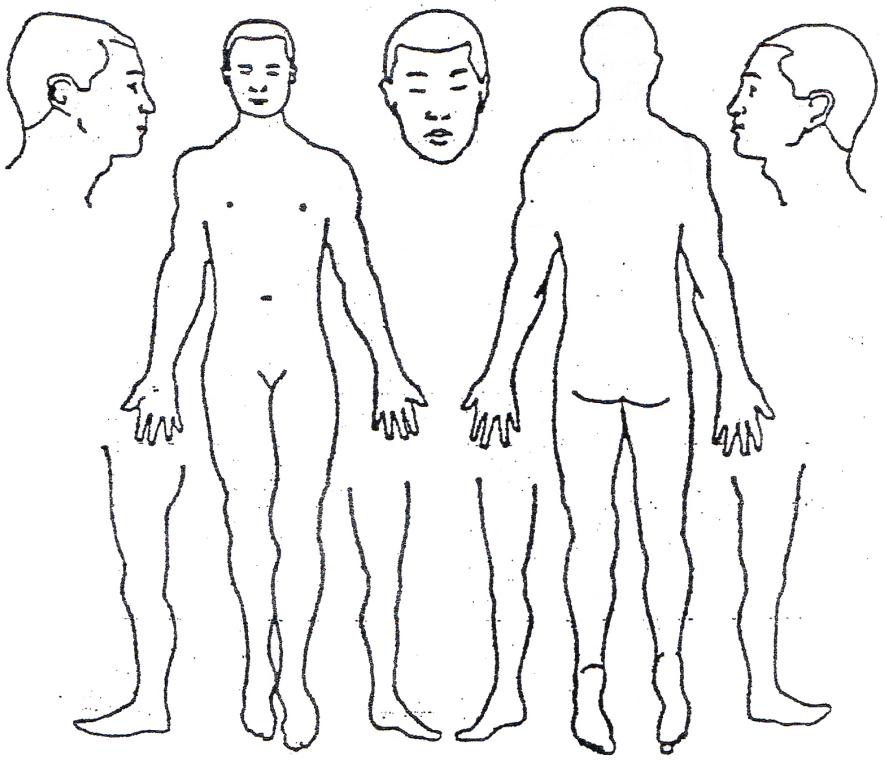
Please note the degree of severity of your problem now:

No Problem — Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No Problem — Worst Imaginable

Indicate painful or distressed areas:



Comments (please tell us any other problems you would like to discuss): _____