COMPREHENSIVE HEALTH QUESTIONNAIRE

Please help us help you by taking the time to complete this questionnaire carefully. All information is confidential. If you have any questions, please ask. If there is anything you wish to bring to our attention that is not mentioned on this form, please inform the acupuncturist or note it at the end of the questionnaire. Thank you!

Name: _____ Date: _____

Birth date: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Marital status: _____

Describe your main problem/s: _____

_____

When did the problem start? _____

Have you had this in the past? If so, when? _____

_____

Did you receive a diagnosis for it? If so, what? _____

_____

What other treatments have you tried? _____

_____

What makes it better? _____

What makes it worse? _____

Current medications/drugs/herbs: _____

_____

Describe any non-medical drug use: _____

Allergies: _____

Please list any surgeries, significant accidents or traumas, and hospitalizations, with dates: _____

_____

_____

_____

_____

Do you have or have you ever had (include dates):

- ☐ Arthritis
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ High/Low Blood Pressure (circle)
- ☐ Heart Disease
- ☐ Insomnia
- ☐ Jaundice
- ☐ Kidney/Bladder Trouble
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Other significant illness:

_____

_____

Has anyone in your family had any of the above? If so, who had what? _____

_____

_____

Name: _____ Date: _____

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Energy level: High (time of day) _____ Low: _____

Stress: ☐ Low ☐ Moderate ☐ High What causes it? _____

Sweating: ☐ Night sweats ☐ Rarely sweat ☐ Excess sweating Other: _____

Temperature: ☐ Tend to feel hot ☐ Tend to feel cold Specific areas of hot/cold: _____

Skin and Hair: ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Burning ☐ Acne ☐ Eczema ☐ Dryness
☐ Clammy/moist ☐ Hair loss/thinning ☐ Dry scalp/dandruff ☐ Bruise easily ☐ Recent moles
☐ Changes in texture of hair or skin Other: _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Excess dreaming
Hours of sleep per night? _____ Other: _____

Head: ☐ Facial pain ☐ Dizziness ☐ Headaches: what area? _____
☐ Concussion Other: _____

Eyes: ☐ Eye pain ☐ Spots in front of eyes ☐ Dry eyes ☐ Night blindness ☐ Color blindness
☐ Blurry vision ☐ Glasses/Lenses ☐ Cataracts ☐ Circles under eyes ☐ Eye strain
Other: _____

Ears: ☐ Poor hearing ☐ Earaches ☐ Ear discharge/infections ☐ Tinnitus Other: _____

Nose/Mouth/Throat: ☐ Sinus problems ☐ Frequent colds ☐ Postnasal drip ☐ Frequent sore throats ☐ Hoarseness
☐ Nosebleeds ☐ Sores in mouth ☐ Dry mouth ☐ Swollen tongue ☐ Teeth grinding
☐ Teeth pain ☐ Root canals ☐ Bleeding gums/gum disease ☐ Jaw pain/clicks
☐ Hard to swallow ☐ Lump in throat Other: _____

Chest: ☐ Cough ☐ Coughing up blood ☐ Bronchitis ☐ Asthma ☐ Pneumonia ☐ Wheezing
☐ Shortness of breath/difficulty breathing ☐ Excessive phlegm: color? _____
☐ Hard to breathe lying down ☐ Pain/pressure in chest ☐ Irregular heartbeat ☐ Phlebitis
☐ Palpitations ☐ Fainting spells ☐ Blood clots ☐ Varicose veins Other: _____

Digestion: ☐ Odd taste in mouth: what taste? _____ ☐ Bad breath ☐ Belching
☐ Nausea ☐ Vomiting ☐ Indigestion ☐ Heartburn ☐ Stomach pain/cramps ☐ Gas
☐ Abdominal pain ☐ Bloating ☐ Diarrhea ☐ Constipation ☐ Bloody stool ☐ Black stool
☐ Mucus in stool ☐ Foul-smelling stool ☐ Hemorrhoids ☐ Irritable Bowel Syndrome
Frequency of bowel movements: _____ ☐ per day ☐ per week Other: _____

Urine: Color: _____ Approximate number of times you urinate a day: _____
☐ Urinary urgency ☐ Pain on urination Frequent urination: ☐ daytime ☐ at night
☐ Dribbling urine ☐ Blood in urine ☐ Difficulty urinating ☐ Strong smelling urine
☐ Water retention ☐ Frequent infections ☐ Kidney stones Other: _____

Females: Last PAP test: _____ Age started periods: _____ Age stopped: _____
☐ Menopausal symptoms: _____
First day of last period: _____ Duration of flow: _____
Time between periods: _____ Color of flow: _____
☐ Irregular periods ☐ Miss periods ☐ Clotting ☐ Menstrual pain ☐ Heavy bleeding
☐ Scanty bleeding ☐ Infertility ☐ Low sex drive ☐ Pregnant
PMS: ☐ Water retention ☐ Mood changes ☐ Painful breasts ☐ Food cravings
Discharge: ☐ Thick ☐ Yellow ☐ White ☐ Odor ☐ Itchy ☐ Liquid
No. Pregnancies: _____ No. Deliveries: _____ No. Miscarriages: _____
No. Abortions: _____ No. Caesareans: _____ Birth control method: _____
Other: _____
_____

Name: _____ Date: _____

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Males: ☐ Prostate trouble ☐ Vasectomy ☐ Impotence ☐ Painful ejaculation ☐ Low sex drive
☐ Premature ejaculation ☐ Discharge ☐ Infertility ☐ Painful genitals
Other: _____

Musculoskeletal: ☐ Painful joints ☐ Bursitis ☐ Grip loss ☐ Stiffness ☐ Muscle cramps ☐ Painful bones
☐ Loss of sensation: where? _____
☐ Weakness: where? _____
☐ Swelling: where? _____
☐ Tingling: where? _____
Pain in: ☐ Neck ☐ Shoulder ☐ Between shoulders ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee
☐ Fingers ☐ Hands ☐ Ankle ☐ Big toe ☐ Midback ☐ Lower back ☐ Soles of feet
Other: _____

Neurological: ☐ Nervous ☐ Depressed ☐ Anxious ☐ Easily angered ☐ Easily irritated ☐ Suicidal
☐ Frequent crying ☐ Mood swings ☐ Poor concentration ☐ Areas of numbness ☐ Neuralgia
☐ Tremors ☐ Loss of balance ☐ Lack of coordination ☐ Poor memory ☐ Shingles
Other: _____

Appetite: ☐ Poor appetite ☐ Excessive appetite ☐ Appetite keeps changing
☐ Weight loss ☐ Weight gain ☐ Feel tired or weak if a meal is missed
Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a big breakfast
Do you eat frequently between meals? ☐ Yes ☐ No
Do you occasionally go on a "crash" diet? ☐ Yes ☐ No
☐ Strong thirst ☐ Never thirsty How many glasses of water a day do you drink? _____
If you drink coffee or soda, how much per day? _____
How many meals a day do you eat? _____ What is your biggest meal? _____
Please list some of your favorite foods: _____
Please describe your average daily diet: _____
_____
_____

If you drink alcohol, how much per week, and what type? _____

If you smoke, how many packs per day? _____ How many years? _____

Do you get any exercise? If so, what kind? _____

Please list any unusual vaccinations or reactions to vaccinations you may remember: _____

_____

Any problems during your birth? _____

Note location of all operation or injury scars (even minor ones): _____

_____

Please list any other issues you would like to discuss: _____

_____

_____

_____

- Thank you -