Four Corners Acupuncture Clinic

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 held absolutely confidential. If you have any questions, please ask. Thank you.

Name_____ Date of Birth_____ Age_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Intersex Email Address _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Height_____ Weight_____ Occupation_____

Family Physician_____ Last seen (date)_____ Referred by_____

Emergency Contact_____ Emergency Contact Phone_____

Relationship status (optional) ☐ Single ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed

Have you been treated by Acupuncture or Chinese Medicine in the past? ☐ Yes ☐ No

_____

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

_____

How long ago did this problem begin?_____

To what extent does this problem interfere with your daily activities?

_____

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

_____

What kinds of treatment have you tried?_____

Past/Current Medical History: (please include date)

☐ Cancer_____	☐ High Blood Pressure_____	☐ Thyroid Disease_____
☐ Seizures_____	☐ Rheumatic Fever_____	☐ Heart Disease_____
☐ Hepatitis_____	☐ Venereal Disease_____	☐ Diabetes_____
☐ HIV_____	☐ Asthma/Pneumonia_____	☐ Anemia_____

Other (include chronic illnesses) _____

_____

Surgeries (type of and date)_____

_____

Significant trauma or hospitalizations (auto accidents, falls, concussions, etc.)_____

_____

Have you used antibiotics in the past?_____

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

Are you currently pregnant?_____ What is your due date?_____

Allergies (drugs, chemicals, foods) _____

What is your reaction? _____

Family Medical History:

	☐ Cancer_____	☐ High Blood Pressure_____	☐ Thyroid Disease_____
	☐ Seizures_____	☐ Heart Disease_____	☐ Diabetes_____
☐ Other_____	☐ Anemia_____	☐ Asthma_____	☐ Hepatitis_____

Medicines taken within the last two months (prescription, over the counter, vitamins, herbs, etc.) Attach list if needed.

_____

_____

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

_____

Do you have a regular exercise program? ☐ Yes ☐ No Please describe_____

_____

Have you ever been on a restricted diet? ☐ Yes ☐ No Please describe_____

_____

Please describe your average daily diet:

Morning_____

Afternoon_____

Evening_____

Do you smoke? ☐ Yes ☐ No How many packs per day?_____

How much coffee, tea or cola do you drink per week? Coffee_____ Tea_____ Cola_____

How much alcohol do you drink per week?_____

Please describe any use of drugs for non-medical purposes_____

Please Rate the Following:

	Great	Good	Fair	Poor	Bad	Comments
Spouse						
Family						
Living Situation						
Diet						
Sex Life						
Self						
Work						
Exercise						
Spirituality						

Please check any symptoms you have had in the last three months:

General

__ Pain: Where:_____
Level (1 - 10)_____
__ Energy level (1 - 10)_____
__ Sudden energy drop
Time of day_____
__ Localized weakness
Where_____
__ Fatigue
__ Poor sleep
__ Sleep disorder
__ Fevers
__ Chills
__ Sweat easily
__ Night sweats
__ Bleed or bruise easily
Time of day_____
__ Edema
Where?_____
__ Tremors
__ Poor balance
__ Weight Gain
__ Weight Loss

Head, Eyes, Ears, Nose & Throat

__ Dizziness
__ Migraines
__ Headaches?
When?_____
Where?_____
__ Facial Pain
__ Glasses
__ Poor vision
__ Night blindness
__ Blurry vision
__ Color Blindness
__ Blind field
__ Spots in front of eyes/floaters
__ Eye Pain
__ Eye Strain
__ Cataracts
__ Eye dryness
__ Excessive tear
__ Discharge from eyes
__ Poor hearing
__ Ringing in ears
__ Earaches
__ Discharge from ear
__ Hearing aide
__ Nose Bleeds
__ Sinus congestion
__ Nasal drainage
__ Loss of consciousness
__ Grinding teeth
__ Teeth problems
__ Jaw clicks
__ Concussions
__ Recurrent sore throats
__ Hoarseness
__ Sore on lips or tongue
Other head or neck problems?
_____

Skin and Hair

__ Rashes
__ Itching
__ Change in hair or skin
__ Ulcerations
__ Eczema
__ Oozing or skin lesion
__ Hives
__ Pimples
__ Recent moles
__ Loss of hair
__ Dandruff
__ Foot fungus
Other hair, skin or foot problems?
_____
_____

Cardiovascular

__ High blood pressure
__ Low blood pressure
__ Chest discomfort/pain
__ Heart Palpitations
__ Cold hands or feet
__ Swelling of hands
__ Swelling of feet
__ Blood clots
__ Fainting
__Other heart or blood vessel problems?_____
_____

Respiratory

__ Allergies
__ Cough
__ Asthma/wheezing
__ Pain with a deep breath
__ Shortness of breath
__ Difficulty inhaling
__ Difficulty exhaling
__ Production of phlegm
What color?_____
__ Coughing blood
__ Pneumonia
__ Bronchitis
__ Other lung problems?_____
_____

Musculo-Skeletal

__ Neck pain
__ Shoulder pain
__ Back pain
__ Elbow pain
__ Hand/wrist pain
__ Hip pain
__ Knee pain
__ Foot/ankle pain
__ Muscle pain
__ Muscle weakness
__ Other muscular/skeletal problems?
_____

Urinary

__ Pain on urination
__ Urgency to urinate
__ Frequent urination
__ Profuse urination
__ Retention of urination
__ Blood in urine
__ Decrease in flow
__ Dribbling
__ Kidney stones
__ Do you wake up to urinate?
Yes___ No___
How often? _____
Urine any particular color?
_____
__Other genital /urinary systems problems?_____
_____

Diet/Gastrointestinal

__ Peculiar taste or smells
__ Strong thirst (cold or hot)
__ Thirst, no desire to drink
__ Cravings? For what?_____
__ Change in appetite
__ Poor appetite
__ Bad Breath
__ Digestive Allergies
__ Nausea
__ Vomiting
__ Heartburn
__ Belching
__ Indigestion
__ Diarrhea
__ Constipation
__ Chronic laxative use
__ Blood in stools
__ Black stools
__ Abdominal pain or cramps
__ Abdomen tense or firm
__ Abdominal distention
__ Epigastric pain
Pain better__ or worse__ with pressure
__ Gas
__ Rectal pain
__ Hemorrhoids
Other stomach or intestinal problems?
_____

Psycho-emotional

__ Insomnia
__ Irritability
__ Loss of control/violence potential
__ Depression
__ Easily susceptible to stress
__ Anxiety
__ Substance abuse
__ Have you ever been treated for emotional problems?
Yes___ No___
__ Have you ever considered or attempted suicide?
Yes___ No___

Neurological

__ Seizures
__ Areas of numbness
__ Weakness
__ Concussion/loss of consciousness
__ Vertigo or dizziness
__ Lack of coordination
__ Loss of balance
__ Poor memory

Sexual/Genital

__ Changes in sexual drive
__ Sores on genitals
__ Pain in genital area
Do you consider your libido normal for your age? Yes__ No__
Too high__ Too low__

Female

__ Age of first menses _____
__ Days between menses _____
__ Number of Days _____
__ First day of last menses _____
__ Heavy periods __ Light periods
Color of blood:
__ Bright red __ Normal red
__ Purple __ Dark Brown
__ Painful periods
__ Irregular periods
__ Changes in body/psyche prior to menstruation?
How?_____
_____
__ Clots
__ Menopause
Age_____ Year_____
__ Vaginal discharge
__ Postcoital bleeding
__ Vaginal sores
__ Date of last pap smear _____
__ Breast lumps
__ Nipple discharge
__ Other issues? Yes___ No___
_____
_____

Pregnancy

Number of pregnancies_____
Number of births_____
Number of premature_____
Number of miscarriages_____
Number of abortions_____
Do you use birth control? Yes___ No___ What type?_____

Male

__ Impotence
__ Prostate problems
__ Premature ejaculation or wet dreams
__ Other issues? Yes___ No____

Other

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

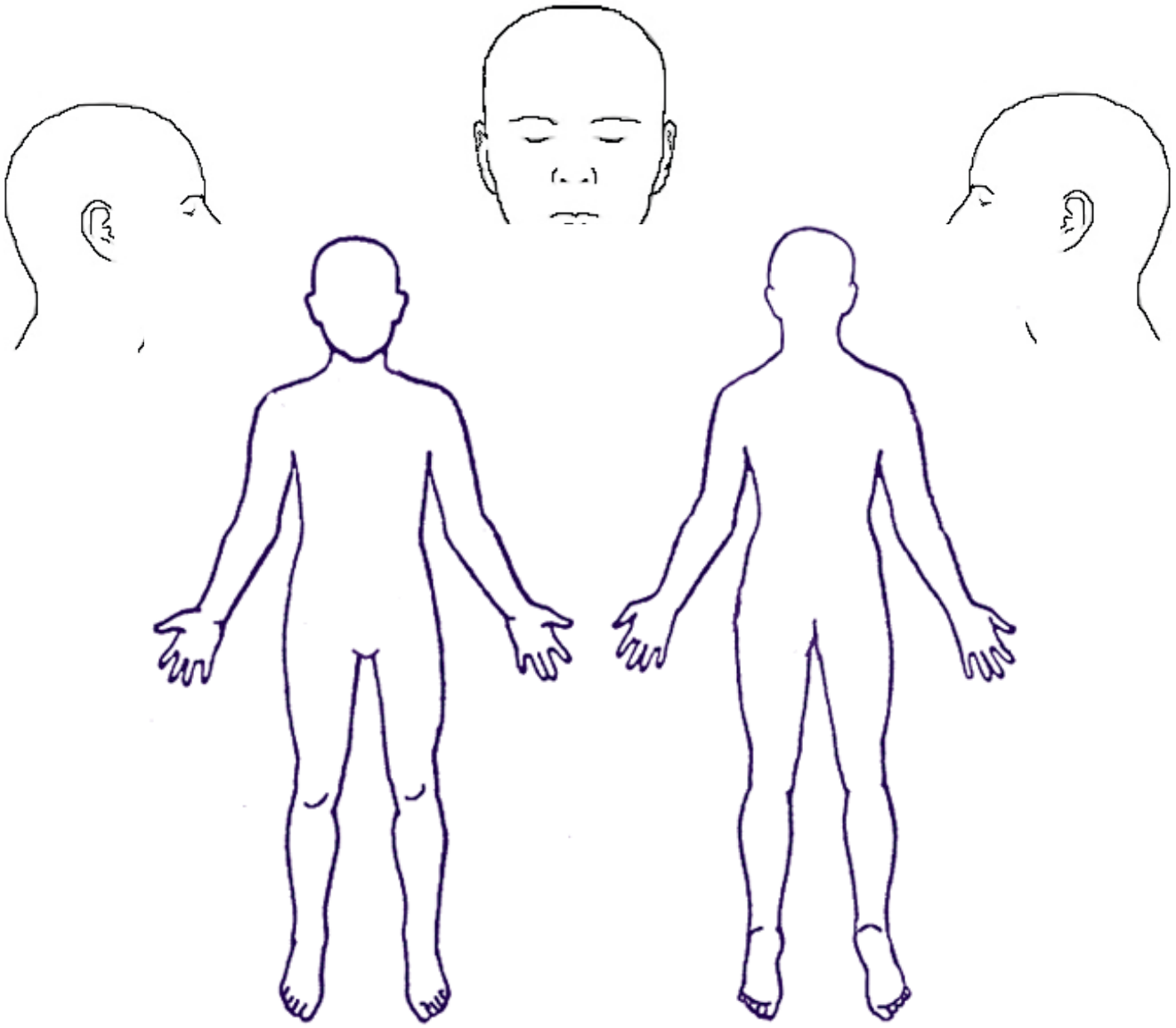
Please note the degree of severity of your main problem now:

No problem Worst imaginable

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

No problem Worst imaginable

Indicate painful or distressed areas:



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Comments: (Please indicate any other problem you would like to discuss):

_____

_____

_____

_____