Health History Questionnaire

Name: _____ Date: _____

Address: _____

City: _____ Zip: _____

Phone (Home): _____ (work/cell) _____

Email: _____

Date of Birth: _____ Occupation: _____

Family Physician: _____

In Emergency, notify: _____ Phone: _____

How did you hear about Susie? _____

Have you ever been treated by acupuncture or Oriental medicine? ☐ Yes ☐ No

Your chief medical problem (the reason you are coming for treatment):

_____

_____

How long ago did this problem begin? _____

Are you seeing your physician for this problem? ☐ Yes ☐ No

Are you seeing: ☐ Chiropractor ☐ Physical Therapist ☐ Psychiatrist/Psychologist

☐ Other (please explain): _____

Are you on a special diet? _____

Name all medications/drugs you are currently taking: _____

_____

_____

Vitamin and herbal Supplements: _____

_____

Name any allergies (drug/environmental): _____

_____

Do you use: ☐ Herbs ☐ Homeopathies ☐ Alcohol ☐ Tobacco

How much caffeinated coffee, tea or soda do you drink per day? _____

_____

What do you do for relaxation? _____

_____

Please check any illness you have had & state the year you first learned of it if possible

- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Heart attach or angina
- ☐ Other heart diseases
- ☐ High blood pressure
- ☐ Blood transfusion
- ☐ Pneumonia, pleurisy
- ☐ HIV _____ AIDS _____
- ☐ Emphysema
- ☐ Allergies
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Jaundice
- ☐ Hepatitis ___A ___B ___C
- ☐ Ulcer
- ☐ Arthritis
- ☐ Bulimia
- ☐ Anorexia
- ☐ Phlebitis
- ☐ Thyroid trouble
- ☐ Venereal disease
- ☐ Tumor
- ☐ Cancer
- ☐ Diabetes
- ☐ Nervous disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Kidney Stones
- ☐ Gall Stones
- ☐ Hernia
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome

Please check alongside those symptoms you are concerned about

- ☐ Poor appetite
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fever, chills
- ☐ Excess sweating
- ☐ Fatigue
- ☐ Eye trouble
- ☐ Ear trouble
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Nasal discomfort
- ☐ Jaw/Gum symptoms
- ☐ Cough
- ☐ Sputum
- ☐ Bloody sputum
- ☐ Wheezing
- ☐ Chest pains
- ☐ Heart palpitations
- ☐ Shortness of breath
- ☐ Swollen feet or ankles
- ☐ Leg pains
- ☐ Varicose veins
- ☐ Jaundice
- ☐ Heartburn
- ☐ Special food tolerance
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching or flatulence
- ☐ Rectal discomfort
- ☐ Diarrhea
- ☐ Constipation
- ☐ Backache
- ☐ Arthritis or joint pain
- ☐ Muscular aches
- ☐ Burning on urination
- ☐ Frequency of urination
- ☐ Difficult urination
- ☐ Night time urination
- ☐ Loss of control of urine
- ☐ Blood in urine
- ☐ Bruise or bleed easily
- ☐ Hot weather intolerance
- ☐ Cold weather intolerance
- ☐ Increased thirst
- ☐ Increased urine volume
- ☐ Skin problems
- ☐ Hair or nail problems
- ☐ Itching
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Tremor
- ☐ Muscle weakness
- ☐ Seizures, convulsions
- ☐ Faulty memory
- ☐ Depression
- ☐ Nervousness
- ☐ Trouble sleeping
- ☐ Work/Family problems
- ☐ Sexual problems
- ☐ Anxiety
- ☐ Phobias

MEN:

- ☐ Weak urine stream
- ☐ Prostate trouble
- ☐ Painful or swollen testicles

WOMEN:

- ☐ Menstrual trouble
- ☐ Vaginal discharges
- ☐ Hot flashes
- ☐ Breast lump/discharge

Date of last period _____

Number of pregnancies ____

Number of miscarriages ____