

ACUTOPIA CHINESE MEDICINE PLLC
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Confidential Patient Health History Questionnaire

Today's date M____D____Y____

Name_____ Nickname_____

Phone (H) _____ (W)_____ (C)_____

Address _____

City _____ State _____ Zip _____ E-mail _____

Age _____ Date of Birth M____D____Y____ Place of Birth _____

Height _____ Weight _____ Marital/Partnership Status _____

Profession/Occupation_____

Family Physician _____ Referred By _____

Emergency Contact _____ Phone _____

Have You Been Treated By Acupuncture or Oriental Medicine Before? Yes No

Main Problem(s) you would like help with _____

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

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

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

What kinds of treatment have you tried? _____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____

Blood Pressure High/Low ____/____ Heart Disease _____ Rheumatic Fever _____

Thyroid Disease _____ Seizures _____ STDs _____ HIV/AIDS _____

Other _____

Surgeries (type of and date) _____

Significant Trauma (auto accidents, falls, etc) _____

Significant Dental Work (type and date) _____

Allergies (drugs, chemicals, foods/result) _____

Family Medical History (check): Diabetes _____ Cancer _____ High Blood Pressure _____

Heart Disease _____ Stroke _____ Seizures _____ Asthma _____ Allergies _____

Other _____

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

Name of Medication/Supplement

Reason for Taking It

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

Do you have a **regular exercise program**? Yes No Please Describe _____

Have you ever been on a **restricted diet**? Yes No What Kind? _____

Are you a smoker? Yes No Quit

If so, how many **packs of cigarettes** do you smoke per day? ____/day

How many caffeinated beverages (**coffee, cola, energy drinks**) do you drink per day? _____

How much **alcohol** do you drink per week? _____

Please describe any use of recreational drugs _____

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

General

Poor appetite
Fevers
Sweat easily
Localized weakness
Bleed or bruise easily
Peculiar tastes or smells
Strong thirst (cold or hot)
No desire to drink
Sudden energy drop
 When? _____
Poor sleep
Chills
Tremors
Poor balance
Fatigue
Night sweats
Cravings
Change in appetite
Weight gain
Weight loss

Skin and Hair

Rashes
Itching
Dandruff
Change in hair or skin
Ulcerations
Eczema
Loss of Hair
Hives
Pimples
Recent moles

Skin and Hair (continued)

Warts
Other hair or skin problems

Musculoskeletal

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

Cardiovascular

High blood pressure
Irregular heartbeat
Cold hands or feet
Blood clots
Low blood pressure
Dizziness
Swelling of hands
Swelling of feet
Phlebitis
Chest pain
Fainting
Difficulty in breathing
Other heart or blood vessel
problems _____

Head, Eyes, Ears, Nose, and Throat

Dizziness
Poor vision
Cataracts
Eye strain
Night blindness
Blurry vision
Spots in front of eyes
Eye pain
Color blindness
Earaches
Ringing in ears (tinnitus)
Poor hearing
Sinus problems
Grinding teeth
Teeth problems
Jaw clicks
Facial pain
Nose bleeds
Recurrent sore throats
Sores on lips or tongue
Concussions
Migraines
Headaches - where and
when _____

Other head or neck
problems _____

Respiratory

- Cough
- Bronchitis
- Pneumonia
- Asthma
- Tuberculosis
- Pain with a deep breath
- Difficulty in breathing when lying down
- Production of phlegm what color _____
- Coughing blood
- Other lung problems _____

Approximately when was your last cold or flu? _____

Gastrointestinal

- Nausea
- Constipation
- Diarrhea
- Chronic laxative use
- Bad breath
- Belching
- Burning sensation
- Abdominal pain or cramps
- Vomiting
- Gas
- Indigestion
- Blood in stools
- Black stools
- Rectal pain
- Rectal burning
- Anal Prolapse
- Hemorrhoids
- Other stomach or intestinal problems _____

Pregnancy and Gynecology

- Number of pregnancies _____
- Number of births _____
- Premature births _____
- Miscarriages _____
- Abortions _____
- Age at first menses _____
- Days between menses _____
- Duration _____
- First day of last menses _____

- Unusual character (heavy or light)
- Painful periods
- Vaginal discharge
- What color? _____
- Changes in body/psyche prior to menstruation
- Clots
- Vaginal sores
- Irregular periods
- Last Pap _____
- Breast lumps
- Fibroid Cysts
- Are you sexually active?__
- Do you practice birth control? Yes No N/A
- What type and for how long? _____

Other Gynecology related concerns _____

Genito-urinary

- Pain on urination
- Urgency to urinate
- Frequent urination
- Unable to hold urine
- Urinary difficulty
- Impotency
- Blood in urine
- Kidney stones
- Sores on genitals
- Other genital or urinary system problems _____

Do you wake up to urinate? Yes No

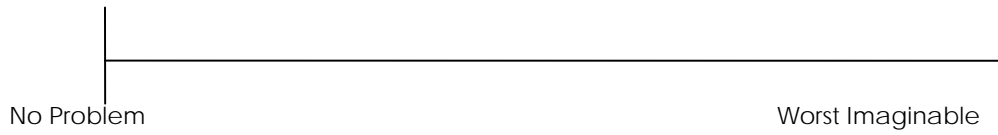
How often? _____

Any particular color to your urine? _____

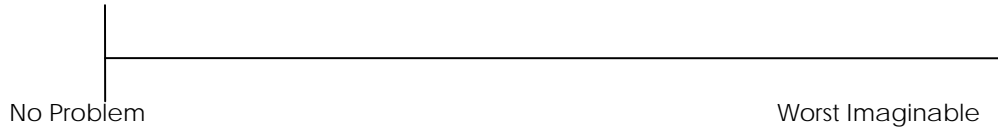
Neuropsychological

- Seizures
- Stroke
- Tremors
- Fainting spells
- Areas of numbness
- Concussion
- Poor memory
- Dizziness
- Vertigo
- Loss of balance
- Lack of coordination
- Depression
- Easily stressed
- Bad temper
- Anxiety
- Difficulty concentrating
- Other neurological or psychological concerns _____

Please note the severity of your main problem now:



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



Comments (please mention any other problems or concerns you would like to discuss)

Indicate painful or distressed areas

