Completed by Office Staff
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# of Visits_____________

Acupuncture Wellness & Fertility Clinic

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New Patient Health History Questionnaire
(Confidential Information)

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but from a Chinese medical perspective they may play a major role in diagnosis and treatment.

All information is strictly confidential.

GENERAL PATIENT INFORMATION

Date: _________________ Name: ____

Address: __________________________________ City, State, Zip: _____________________________

Home Phone: _________________ Work Phone: __________________ Cell Phone: ______________

Age: ______ Date of Birth: ___________________ Email: ______________________________________

Legal Guardian: (if under 18 years of age) ____

Emergency Contact: (name and phone number) ____

Gender: ___ M ___ F Height:____ ' ___" Weight:____lbs

Occupation: _________________________________ Employer:__________________________________

How did you hear about us? ____

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

(If pain related, please include severity from 1-10 (mild-extreme) & percentage of time you experience pain in a 24 hour period next to complaint)

1. ____ 2. ____

3. ____ 4. ____

5. ____ 6. ____

Which activities are difficult to perform if your issue is pain related?

Sitting *Bending* *Standing* *Lying Down* *Walking* *Lifting* *other*________________

Does your pain interfere with your: *Sleeping* *Dressing* *Tying Shoes* *W ork performance* *Bathing* *Preparing Food*

Eating *Taking Medicine* *Walking* *Exercising*

PATIENT MEDICAL HISTORY

How was your childhood health? ____

Hospital visits/stays: ____

Recent Tests: (please indicate test results and date below)

•Physical •Cholesterol •Prostate •Blood (which?) •HIV/STD •Pap Smear •Mammography •Other

Test results and date: ____

Check any that you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein Condition	☐ Thyroid Disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding Tendency
☐ Syphilis	☐ Measles	☐ Chicken Pox	☐ Nervous Disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Mononucleosis
☐ Epilepsy	☐ High Fever	☐ Hepatitis	☐ Multiple Sclerosis
☐ Paralysis	☐ Cancer	☐ Migraines	☐ High Blood Pressure
☐ Other Lung Illness	☐ Other Liver Illness	☐ Other Heart Illness	☐ Other Kidney Illness

☐ Other ____

Immunizations: ____

Surgeries: ____

PATIENT PROFILE

Please clearly mark any areas of pain and any scares (please indicate which of the areas are scars)

Is the pain:

☐ Sharp ☐ Burning ☐ Aching

☐ Cramping ☐ Dull ☐ Moving

☐ Fixed ☐ Other: ____________________

Do the following improve the pain?

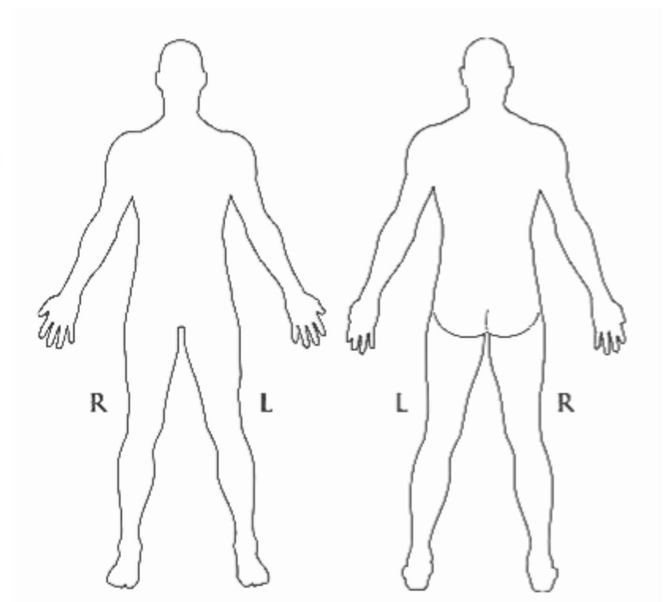
☐ Pressure ☐ Cold ☐ Heat

☐ Exercise ☐ Other: ____________________

Do the following worsen the pain?

☐ Pressure ☐ Heat

☐ Cold ☐ Other: ____________________



Please check the following that currently pertain to you.

ENERGY

- ☐ Shortness of breath
- ☐ Low energy
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Feel worse after exercise
- ☐ Difficulty keeping eyes open in the daytime

OVERALL TEMPERATURE

- ☐ Sweaty feet
- ☐ Hot body temperature (sensation)
- ☐ Cold body temperature (sensation)
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet, and chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Take water to bed

BLOOD

- ☐ Dizziness
- ☐ See floating black spots

HEART

- ☐ Palpitations
- ☐ Anxiety
- ☐ Drink coffee (# of cups per week:_______)
- ☐ Sores on the tip of the tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed

Lu n g

- ☐ Nasal Discharge (Color: _______________)
- ☐ Allergies (To what?____________________)
- ☐ Headache (Location: __________________)
- ☐ Smoke cigarettes (# of cigarettes a day: ___)
- ☐ Alternating fever and chills
- ☐ Coughs
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Sadness
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Sneezing
- ☐ Achy feeling
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Melancholy

Spl een

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Prolapsed organs (previously diagnosed, which organ? ____________)
- ☐ Abdominal gas
- ☐ Gurgling noise in the stomach
- ☐ Fatigue after eating
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Worry
- ☐ Over-thinking

Spl een , st o m a ch , l ar g e in t est in e, smal l in t est in e

- ☐ Loose
- ☐ Constipated
- ☐ Incomplete
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

Stomach

- ☐ Large appetite
- ☐ Bad breath
- ☐ Mouth (canker) sores
- ☐ Burning sensation after eating
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer (diagnosed)
- ☐ Bleeding, swollen or painful gums
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach pain
- ☐ Vomiting

DAMPNESS

- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ General sensation of heaviness in the body
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

LIVER, GALL BLADDER

- ☐ Alternating diarrhea and constipation
- ☐ Headache at the top of the head
- ☐ Tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ High-pitched ringing in the ears
- ☐ Gall stones (history or current)
- ☐ Limited Range-of-Motion, neck
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Skin rashes
- ☐ Chest pain
- ☐ Anger easily
- ☐ Limited Range-of-Motion, shoulder
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Sexually transmitted disease (Which?____)
- ☐ Recreational drugs (Which? _________________ , How much per week? ________)
- ☐ Frequently unable to adapt to stress (What causes the stress?___________________)

EYES

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

Kidney, urinary bladder

- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in the knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing the ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Wake during the night twice to urinate
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

Urination

- ☐ Normal color
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong color
- ☐ Burning
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

LIBIDO

- ☐ Normal
- ☐ High
- ☐ Low

women only

Regular menstrual cycle? ☐ Y ☐ N Number of children: _______ Age of first menstruation: ________

Average number of days of flow: ___________ Vaginal discharge? ☐ Y ☐ N Pregnant? ☐ Y ☐ N

Number of pregnancies:__________________ Age of menopause (if applicable): ____________________

Average number of days of entire cycle: ______________________ Bleeding between periods? ☐ Y ☐ N

Do you experience any of the following pre-menstrual syndromes?

☐ Nausea ☐ Vomiting ☐ Water retention ☐ Breast swelling

☐ Food cravings ☐ Headaches ☐ Migraines ☐ Breast tenderness

☐ Depression ☐ Irritability ☐ Anxiety ☐ Other emotions

☐ Dull pain, Where?________________ ☐ Sharp pain, Where? _________________

Please fill out the following menstrual chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

MEN ONLY

☐ Swollen testes ☐ Testicular pain ☐ Impotence Premature

☐ Feeling of coldness or numbness in external genitalia ☐ Other____________________________

Everyone: Medications, vitamins and supplement log

Medical/Allergy alerts:

Dietary Intake

Please list typical foods eaten for each meal and amount of beverages consumed each day of the

Diet:	
Beverages/Day:	
Breakfast:	Water:
Lunch:	Pop:
Dinner:	Milk:
Snacks:	Juice:
	Coffee: