Health History Questionnaire

I. General Patient Informaion

Date: ___/___/___ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Marital Status: _____

Preferred Phone _____ (H/C/W) Secondary Phone _____ (H/C/W)

Age: _____ Date of Birth ___/___/___ Place of Birth: _____

Guardian (if under 18): _____

Height: ___'___" Weight: _____ lbs

Email: _____

Driver's License Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____

State: _____ Zip: _____

Who we may thank for referring you?

Recent health care providers: Name, Date, Service Provided:

Main concern: _____

How does this problem affect your daily activities? _____

When did you first notice symptoms? _____

If you have been diagnosed, what is the diagnosis? _____

What kinds of treatments or therapies have you tried? _____

Results: _____

Any medications: _____

Supplements: _____

Allergies: _____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	☐	☐	☐	☐	_____
2.	☐	☐	☐	☐	_____
3.	☐	☐	☐	☐	_____
4.	☐	☐	☐	☐	_____
5.	☐	☐	☐	☐	_____
6.	☐	☐	☐	☐	_____
7.	☐	☐	☐	☐	_____
8.	☐	☐	☐	☐	_____
9.	☐	☐	☐	☐	_____
10.	☐	☐	☐	☐	_____

How do these conditions impair your daily activities?_____

_____

II. 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 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 illnesses	☐ other liver illnesses	☐ other heart illnesses	☐ other kidney illnesses
☐ other spleen illnesses		☐ other stomach illnesses	

☐ other:_____

Immunizations:_____

Surgeries:_____

III. Family History

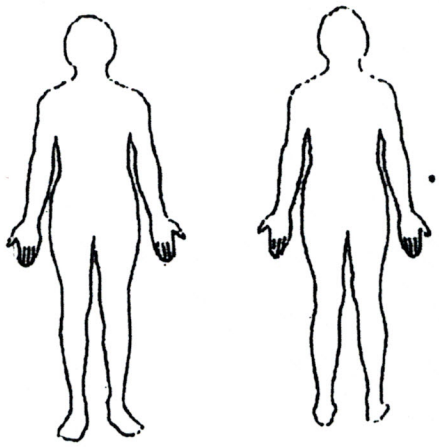
Family member	Alive	Deceased	Present health or cause of death
Father	☐	☐	
Mother	☐	☐	
Spouse	☐	☐	
Children	☐	☐	
Brother	☐	☐	
Brother	☐	☐	
Brother	☐	☐	
Sister	☐	☐	
Sister	☐	☐	
Sister	☐	☐	

Where are you in the birth order? ☐ first ☐ last ☐ middle ☐ only
Check the following that have occurred in your blood relatives:

☐ Diabetes	☐ Cancer	☐ Heart disease	☐ High blood pressure
☐ Allergies	☐ Tuberculosis	☐ Obesity	☐ Bleeding tendency
☐ Kidney disease	☐ Alcoholism	☐ Nervous Illness	☐ Mental illness
☐ Stroke	☐ Other_____		

IV. Patient Profile

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



Is the pain:
☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed ☐ Other:_____

Do the following lessen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Exercise ☐ Other:_____

Do the following worsen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Other:_____

Please check the following that pertain to you:

Overall Temperature (Kidney function):
☐ Cold hands
☐ Cold feet
☐ Sweaty hands
☐ 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
- ☐ Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney function):
- ☐ Shortness of breath
- ☐ Difficulty keeping eyes open in the daytime
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise

Blood (Liver, Spleen, Heart function):
- ☐ Dizziness
- ☐ See floating black spots

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

Lung function:
- ☐ Nasal Discharge (Color: _____)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies (To what?_____)
- ☐ Alternating fever and chills
- ☐ Sneezing
- ☐ Headache (Location: _____)
- ☐ Overall achy feeling in the body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# of cigarettes per day: _____)
- ☐ Sadness
- ☐ Melancholy

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

Spleen, Stomach, Large Intestine, Small Intestine function:
- ☐ Loose
- ☐ Constipated
- ☐ Incomplete
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

Dampness trapped in the body:
- ☐ General sensation of heaviness in the body
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess

- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

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

Liver, Gall Bladder function:
- ☐ Alternating diarrhea and constipation
- ☐ Chest pain
- ☐ Tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Anger easily
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Frequently unable to adapt to stress (What causes the stress? _____)
- ☐ Skin rashes
- ☐ Headache at the top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck tension
- ☐ Limited Range-of-Motion, Neck
- ☐ Shoulder tension
- ☐ Limited Range-of-Motion, Shoulder
- ☐ Drink alcohol
- ☐ Recreational drugs (Which? _____, How much per week? _____)
- ☐ High-pitched ringing in the ears
- ☐ Gall stones (history or current)
- ☐ Sexually transmitted disease (Which? _____)

Eyes (Liver function):
- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

Kidney, Urinary Bladder function:
- ☐ 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 in the ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Wake during the night twice or more to urinate

☐ Lack of bladder control
☐ Fear
☐ Easily startled

Urination:
☐ Normal color
☐ Dark yellow
☐ Clear
☐ Reddish
☐ Cloudy
☐ Scanty
☐ Profuse
☐ Strong odor
☐ Burning
☐ Painful

☐ Discharge
☐ Difficult
☐ Painful
☐ Urgent
☐ Frequent

Libido:
☐ Normal
☐ High
☐ Low

Other symptoms:

Women only:

Regular menstrual cycle? ☐ Y ☐ N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
cycle:_____

Pregnant? ☐ Y ☐ N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire

	Severe	Moderate	Slight	Normal
Vaginal discharge:	☐	☐	☐	☐
Bleeding between periods:	☐	☐	☐	☐

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

☐ nausea ☐ food cravings ☐ depression ☐ vomiting
☐ headaches ☐ irritability ☐ water retention ☐ migraines
☐ anxiety ☐ breast swelling ☐ breast tenderness
☐ other emotions:_____ ☐ dull pain, where?_____
☐ sharp pain, where?_____
☐ Other: _____

Please fill in the following menstrual chart: , even if you do not have periods.
(Put in a number and what color it is)

	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:

	Severe	Moderate	Slight	Normal
☐ Swollen testes	☐	☐	☐	☐
☐ Testicular pain	☐	☐	☐	☐
☐ Impotence	☐	☐	☐	☐
☐ Premature ejaculation	☐	☐	☐	☐
☐ Feeling of coldness or numbness in external genitalia	☐	☐	☐	☐
☐ Other_____	☐	☐	☐	☐

All please fill out:

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____

Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

HIPPA

Notice of Privacy Practices

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Shannon Smith

Address: 1100 Parkway Drive, Suite B, Goldsboro, NC 27534

Telephone No.: 919-751-1155

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

Informed Consent Form

Please read this entire document carefully prior to signing. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

Is Acupuncture safe?

Yes, but the common side effects of an acupuncture treatment are listed below.

- Drowsiness may occur after a treatment. If you are so affected, you are advised not to drive.
- Minor bleeding or bruising may occur when the needles are removed.
- Indwelling ear needles can become painful or inflamed. If this occurs, promptly remove the needle(s) involved.
- Symptoms can get worse after a treatment. Be sure to tell your doctor about this at your next appointment.
- Fainting may occur in certain patients, particularly at the first treatment.

Cupping and Gua Sha

- These techniques may cause redness and petechiae (small red/purple bumps). This is a normal presentation and no other action needs to be taken
- The redness and bumps will dissipate typically within 1-3 days, but can take up to a week.

Moxibustion

- A burn may occur during the use of moxibustion. This is rare, but can happen
- Notify the doctor if a burn shows up after treatment.
- Always let the practitioner know if the moxibustion is getting too hot

In addition, if there are particular risks that apply in your case, your doctor will discuss these with you.

Is there anything your doctor needs to know?

Apart from the usual medical details, it is important to tell you doctor.

- If you have ever become faint or had a seizure,
- If you have a bleeding disorder,
- If you are taking anticoagulants or any other medication,
- If you have a damaged heart valve, a pacemaker or other cardiac problem,
- If you have any other particular risk of infection.

Only single-use, sterile, disposable needles are used in the clinic.

Statement of Consent

I confirm that I have read and understood the above information. I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature

Print Name Date