



## Health History Questionnaire

*All of the information provided is strictly confidential*

### General Patient Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
E- Mail Address: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Soc. Security#: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_  
Spouses Occupation: \_\_\_\_\_  
Emergency Contact Name & Phone Number: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Name of Primary Health Care Provider (not insurance): \_\_\_\_\_  
PHCP Phone Number: \_\_\_\_\_  
Other Health Care Providers & Phone Numbers: \_\_\_\_\_  
\_\_\_\_\_

### Major Health Complaints

Major Health Complaints or Symptoms	How Long	Alleviating Factors	Aggravating Factors

What treatments have you tried? \_\_\_\_\_

\_\_\_\_\_

Please describe how these problems affect your daily living: \_\_\_\_\_

\_\_\_\_\_

Please list any other current conditions or complaints you would like us to know about:

\_\_\_\_\_

\_\_\_\_\_

### **Past Medical History**

Please describe your childhood health: \_\_\_\_\_

\_\_\_\_\_

**Please circle all that apply to you:**

Addictions	COPD	High Blood Pressure	Polio
Alcoholism	Diabetes	High Cholesterol	Prostate Problems
Anemia	Eating Disorder	HIV/AIDS	Rheumatism
Appendicitis	Emotional Imbalance	Joint Problems	Stroke
Arteriosclerosis	Epilepsy	Kidney Disease	STD
Arthritis	Fibromyalgia	Liver Disease	Tremors
Asthma	Gall Stones/Gall Bladder	Malaria	Thyroid Problems
Bladder Disease	Inflammation	Meningitis	Ulcers
Breast Lumps	Glaucoma	Menstrual Problems	
Breathing Problems	Goiter	Mononucleosis/Epstein-	Chronic Pain
Cancer	Gout	Barr	Obesity
Candida	Heart Disease	Multiple Sclerosis	Smoking
Chronic Fatigue	Hernia	Nephritis	
Crohns/Colitis	Hepatitis	Neuralgia	

Other: \_\_\_\_\_

Surgeries and Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Significant Traumas: \_\_\_\_\_

Allergies (drugs, chemicals, food, airborne): \_\_\_\_\_

\_\_\_\_\_

Current Medications, Supplements, and/or Herbs: \_\_\_\_\_

\_\_\_\_\_

Recent Medical Tests or Procedures (please indicate test date and results):

\_\_\_\_\_

\_\_\_\_\_

**Daily Routine Assessment**

Do You Smoke? \_\_\_\_\_ Cigarettes per Day : \_\_\_\_\_ for How Long: \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ What kinds? And how much of each?  
\_\_\_\_\_

Do you drink caffeinated beverages? \_\_\_\_\_ What kinds? And how much of each?  
\_\_\_\_\_

Please describe your exercise routine: \_\_\_\_\_

Please describe your daily diet below (breakfast, lunch, dinner, snacks, beverages)

Breakfast \_\_\_\_\_ When \_\_\_\_\_

Lunch \_\_\_\_\_ When \_\_\_\_\_

Dinner \_\_\_\_\_ When \_\_\_\_\_

Snacks \_\_\_\_\_ When \_\_\_\_\_ When \_\_\_\_\_

**General Health Self Assessment**

If you do not take steps to improve your health and / or symptoms now, do you think your condition will get worse?  Yes  No

If your condition continues on its current course, what do you think your symptoms will be like 5 years from now?  
\_\_\_\_\_  
\_\_\_\_\_

What do you think is most preventing you from being healthy? \_\_\_\_\_  
\_\_\_\_\_

What are 5 things that you know you could do to improve your health? (1) \_\_\_\_\_

(2) \_\_\_\_\_ (3) \_\_\_\_\_

(4) \_\_\_\_\_ (5) \_\_\_\_\_

On a scale of 1-10, how committed are you to becoming healthy? (circle one)

1 2 3 4 5 6 7 8 9 10

**Pursuant to the requirements of Section 6.11, Subsection (d) V. A. C. S., article 4495b, governing the practice of Acupuncture**

I (patient's name) \_\_\_\_\_, am notifying the licensed acupuncturist, of the following:

I have been evaluated by a physician or dentist for the condition(s) being treated within the 6 months before this acupuncture treatment was performed. Yes \_\_\_\_ No \_\_\_\_

I recognize that I should be evaluated by a physician for the current condition(s) or any future condition(s) treated by the licensed acupuncturist \_\_\_\_\_ (patient initials)

I understand that the following conditions do not require evaluation from a physician within the last 6 months:

Smoking Cessation    Weight Loss    Chronic Pain (please circle those that apply)

I have received a referral from my chiropractor within the last 30 days for acupuncture. Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the licensed acupuncturist is required to refer me to a physician. It is my responsibility and **choice** whether to follow this advice.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Licensed Acupuncturist \_\_\_\_\_ Date: \_\_\_\_\_

**Preferred Method of Contact**

As a service to you we would like to leave appointment reminders and follow-up with you after your appointment. Please indicate below your preferred method(s) of contact:

Home Phone     Work Phone     Cell Phone     E-Mail

I prefer that no one from AHHA attempt to reach me for appointment reminders and follow-up.

You may also designate an individual with whom we may release information concerning your care if we are unable to reach you.

Name of Designee: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# AHHA Patient Profile

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## Overall Body Temperature (Kidney Organ System)

- |                                       |  |   |   |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Cold hands   | <input type="checkbox"/> Hot body temperature  | <input type="checkbox"/> Profuse perspiration | <input type="checkbox"/> Perspire easily      |
| <input type="checkbox"/> Cold feet    | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Afternoon flushing    | <input type="checkbox"/> Night sweating       |   |
| <input type="checkbox"/> Sweaty feet  | <input type="checkbox"/> Hot flashes           | <input type="checkbox"/> Strong thirst        |   |

Notes: \_\_\_\_\_

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## Overall Energy (Lung and Kidney System)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Easily fatigued     | <input type="checkbox"/> Lethargy                  | <input type="checkbox"/> Prone to illness         | <input type="checkbox"/> Wheezing          |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sweating without exertion | <input type="checkbox"/> Frequent colds /<br>flus | <input type="checkbox"/> Chronic allergies |
- 
- 

## Blood Function (Liver, Heart and Spleen System)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Tingling in extremities  | <input type="checkbox"/> Itchy or dry  | <input type="checkbox"/> Blurry vision         |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Poor memory              | <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Tinnitus              |
| <input type="checkbox"/> Floaters          | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Weak or brittle nails |
- 
- 

## Heart Function

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Manic moods     | <input type="checkbox"/> Forgetfulness  | <input type="checkbox"/> Tongue ulcers        |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Speech<br>impediment |
| <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia        | <input type="checkbox"/> Depression     | <input type="checkbox"/> Severe shyness       |
- 
- 

## Lung Function

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Dry or flaky skin | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Nosebleeds       | <input type="checkbox"/> Nasal dryness     | <input type="checkbox"/> Sneezing          | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats      | <input type="checkbox"/> Wheezing          | <input type="checkbox"/> Cigarette smoking    |
- 
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**Spleen Function**

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Abdominal bloating   | <input type="checkbox"/> Gurgling in intestines   | <input type="checkbox"/> Hemorrhoids  |
| <input type="checkbox"/> Abrupt weight gain   | <input type="checkbox"/> Gas                  | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight loss   | <input type="checkbox"/> Strong food cravings | <input type="checkbox"/> Bruise easily            | <input type="checkbox"/> Indigestion  |

**Stomach Function**

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Stomach ache      | <input type="checkbox"/> Bad breath    | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea       |
| <input type="checkbox"/> Acid reflux       | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching      | <input type="checkbox"/> Vomiting     |
| <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Heartburn     | <input type="checkbox"/> Hiccups       | <input type="checkbox"/> Mouth ulcers |

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Bowel Function and Elimination** (Intestinal Function)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Loose stools      | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Difficulty moving bowels |
| <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Blood in stools  | <input type="checkbox"/> Small, hard, dry stools  |
| <input type="checkbox"/> Incomplete stools | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Less than 1 BM/ Day      |

\_\_\_\_\_  
\_\_\_\_\_

**Accumulated Dampness**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Mental fogginess                                       | <input type="checkbox"/> Swollen hands          | <input type="checkbox"/> Edema in the legs                |
| <input type="checkbox"/> Mental sluggishness                                    | <input type="checkbox"/> Swollen feet           | <input type="checkbox"/> Edema in the abdomen             |
| <input type="checkbox"/> Poor mental focus                                      | <input type="checkbox"/> Joint stiffness / ache | <input type="checkbox"/> Chest congestion                 |
| <input type="checkbox"/> Heaviness of the head, the limbs, or of the whole body |   | <input type="checkbox"/> Symptoms worsen in rainy weather |

\_\_\_\_\_  
\_\_\_\_\_

**Eyes** (Liver Function)

- |                                      |  |                                       |                                      |
|--------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Itchy eyes  | <input type="checkbox"/> Grittiness        | <input type="checkbox"/> Bloodshot    | <input type="checkbox"/> Far sighted |
| <input type="checkbox"/> Dry eyes    | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Seeing spots | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Red and irritated | <input type="checkbox"/> Near sighted | <input type="checkbox"/> Glaucoma    |

\_\_\_\_\_  
\_\_\_\_\_

**Liver and Gall Bladder Function**

- Chest pain
- Chest tightness
- All over body tension
- Irritability
- Easy to anger
- Easily frustrated
- Depression
- Pain in the ribcage
- Heaviness in ribcage
- Chronic neck tension
- Shoulder tension
- Ringing in ears
- Skin rashes
- Acne
- Headaches
- Muscle spasms
- Muscle cramps
- Seizures
- Convulsions
- Numbness / tingling
- Lump in throat
- Migraines
- Gall stones
- Eye pain / dryness
- Alternating diarrhea and constipation
- Easily overwhelmed by stressful circumstances

Notes:

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**Kidney and Urinary Bladder Function**

- Frequent cavities
- Broken / loose teeth
- Weak bones
- Low-pitched ringing in the ears
- Weak knees
- Knee soreness
- Low back pain
- Cold lower back
- Cold hips / buttocks
- Cold knees
- Incontinence
- Hair loss
- Early graying of hair
- Hearing loss
- Quick to fear / fright

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**Urinary Function**

- Normal color
- Dark Yellow
- Clear color
- Difficulty initiating the stream of urination
- Reddish color
- Cloudy
- Strong odor
- Small amount
- Large amount
- Very frequent
- Dribbling
- Night-time urination
- Pain or burning
- Hesitancy
- Weak stream

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**Libido Function**

- Normal
- Early ejaculation
- Difficulty getting or maintaining an erection
- High sex drive
- Spermatorrhea
- Diminished sex drive
- Nocturnal emissions
- Fatigue following sexual activity
- Vaginal dryness
- Infertility

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