HAMILTON HOLISTIC WELLNESS CENTER - ACUPUNCTURE
PATIENT HEALTH HISTORY QUESTIONNAIRE

Important: Complete this document! All information is strictly confidential.

I. GENERAL PATIENT INFORMATION Date: ____/____/_____

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: (____)_____ Work/Cell Phone: (____)_____

Email address: _____

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

Guardian (if under 18 years of age): _____

Gender: □M □F Height: ____'____" Weight: _____ lbs. Marital Status: ____

Occupation: _____ Employer: _____

How did you FIRST hear about our office?

- Google Search: ____
- Health Profs: ____
- Yelp: ____
- Website: ____
- Primary Care Physician: ____
- Specialty Group (Name): _____
- Newspaper Ad/Article (Name): _____
- Friend/Family/Co-Worker (Name): _____
- Insurance Company (Name): _____
- Other: _____

Family Physician: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Emergency Contact Information:
Name:_____
Phone Number:_____
Relation to Patient:_____

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No (please circle)

If yes, when was last time and for what condition:

Main Conditions you would like us to help you with, in order of significance:

1. **4.**

2. **5.**

3. **6.**

How long ago did these problem(s) begin; please be specific:

To what extent do these problems affect your daily activities, such as work, sleep or hobbies?

What kinds of treatment have you tried, and how have they worked?

Have you been given a diagnosis for any of these problems, if so, what?

II. PAST MEDICAL HISTORY

How was your childhood health?

List all Hospitalizations, Surgeries, Auto Accidents, Trauma, Falls and dates:

Allergies (food, seasonal, medication, environmental):

Recent Tests (Please indicate test results and date):

Physical Cholesterol Prostate Blood (which) HIV/STD

Pap Smear Mammography Other: _____

Significant Test Results and Dates: _____

Circle any you have had in the past:

Diabetes	Allergies	Glaucoma	Rheumatic Fever	Heart Disease	CVA (Stroke)
Vein condition	Asthma	Pneumonia	Tuberculosis	Emphysema	Mumps
Jaundice	Gonorrhea	Syphilis	Bleeding Tendency	Measles	High Fever
Meningitis	Chicken Pox	Epilepsy	Nervous Disorder	High Fever	Hepatitis
Mononucleosis	HIV/AIDS	Polio	Thyroid Disorder	Paralysis	Cancer
Migraines	Diabetes	Hepatitis	High Blood Pressure	Lung Disorder	Liver Disorder

Kidney Disorder Spleen Disorder Stomach Disorder

Other: _____

Immunizations:

Family Medical History: Please circle all that apply in your immediate family

Cancer Diabetes High Blood Pressure Stroke Seizures

Allergies Asthma Heart Disease

Other Major Illnesses:

III. PATIENT PROFILE

Please list all medications taken in the last 3 months (including drugs, vitamins and herbs):

Occupational Stress (chemical, physical, psychological, etc.):

Do you have a regular exercise program? If yes, describe:

Are you on a restricted diet? If yes, describe:

Do you drink alcohol? How often and how much?

How many caffeinated drinks do you drink per week (coffee, tea, soda)?

Do you smoke? If yes, how many cigarettes per day?

Pain Conditions:
Indicate any areas of pain in the body and the location of any scars on the body:
Is the pain sensation:
Sharp Burning Aching Cramping Dull Moving Fixed
Other:

Do any of the following lessen the pain:
Pressure Cold Heat Exercise Other:

Do any of the following worsen the pain:
Pressure Cold Heat Exercise Other:

Please check the following that pertain to you:
Overall Temperature (Kidney Function):
□ Hot body temperature or sensation □ Cold hands □ Sweaty hands □ PM flushes
□ Cold body temperature of sensation □Cold feet □ Sweaty feet □ Night sweats
□ Heat in the hands, feet and chest □ Hot flashes any time of the day □ Seldom sweats
□ Perspire easily □ Thirsty: for hot or cold drinks

Overall Energy (Lung and Kidney Function):
□ Difficulty keeping eyes open in the daytime □ Shortness of breath □ General weakness
□ Easily catch colds □ Low Energy □ Feel worse after exercise

Overall Blood Function:
□ See floaters or floating black spots in the eyes □ Recent moles, unusual moles
□ Freckles □ Dizziness □ Pimples

Eyes: (Liver Function)
□ Itchy □ Red or Bloodshot □ Hot □ Dry □ Watery □ Gritty or sandy feeling
□ Blurry vision □ Decreased night vision □ Near-sighted □ Far-sighted
□ Cataracts □ Visual Disturbance

Liver and Gallbladder Function:
□Chest pains □Tight sensation in chest □Bitter taste in mouth
□Anger easily □Frustration □Depression
□Irritability □Skin rashes □Tingling sensations
□Numbness □Muscle Spasms □Muscle Twitching
□Muscle Cramping □Seizures □Convulsions
□Lump in throat □Teeth Grinding □Alternating diarrhea and constipation
□Neck tension □Shoulder tension □Hip pain/Sciatica
□Drink alcohol □Recreational drugs (which, how much per week?)
□High pitch ringing in the ears □Gallstones, history of or currently
□Sexually transmitted diseases (which) □Genital sores
□Frequently unable to adapt to stress (what causes this stress?)
□Migraines □ Headaches: How Often? Describe location:

Heart Function:
□ Cardiovascular disease □ High blood pressure □ Low blood pressure
□ Chest pain □ Fainting □ Palpitations □ Sores on tip of tongue
□ Restlessness □ Anxiety □ Hard to fall asleep □ Wake unrefreshed
□ Nightmares □ Restless sleep □ Mental Confusion □ Restless dreaming
□ Waking during the night □ Chest pain traveling to shoulders or down arms

Spleen Function:
□ Low appetite □ Changes in appetite □ Cravings, for what?
□ Abrupt weight gain □ Abrupt weight loss □ Abdominal bloating
□ Abdominal gas □ Stomach Gurgling □ Fatigue after eating
□ Easily bruised □ Hemorrhoids □ Pensive/Over-thinking
□ Worry □ Prolapsed organs: which organ?

Spleen, Stomach, Large Intestine, Small Intestine Function:
□ Loose Stools □ Incomplete Bowel Movements □ Constipation
□ Diarrhea □ Blood in Stools □ Undigested food in stools
□ Mucous in stools □ Black or tarry stools □ Chronic use of laxatives: what type of laxative?

Stomach Function:
□ Burning sensation after eating □ Large appetite □ Bad breath □ Vomiting
□ Sores on lips, tongue or mouth □ Ulcer (if diagnosed) □ Belching □ Acid regurgitation
□ Cold sensation in stomach □ Hiccoughs □ Stomach Pain □ Heartburn
□ Bleeding, swollen or painful gums

Lung Function:
□ Profuse nasal discharge: thin/clear/runny thick/white thick/yellow
□ Cough: Wet or Dry □ Nose Bleeds □ Sinus Congestion □ Dry mouth
□ Dry, itchy throat □ Sore throat □ Dry skin □ Allergies: to what?
□ Sneezing □ Hives □ Stiff neck □ Stiff shoulders

□Bronchitis □Rashes □Itching □Eczema
□ Dandruff □ Sadness □ Melancholy □Difficulty inhale or exhale
□ Alternating fever and chills □ Achy feeling in the body □Smoke cigarettes

Kidney, Urinary Bladder Function:
□ Frequent cavities □ Easily Broken Bones □ Poor hearing □ Earaches
□ Painful knees □ Weak knees □ Cold in knees □ Low back pain
□ Memory problems □ Excessive hair loss □ Pre-mature grey hair □ Low-pitch ringing in the ears
□ Kidney stones □ Bladder infections □ Fear □ Easily startled
□ Foot or ankle weakness or pain □ Lack bladder control □ Sneeze or jump incontinence

Dampness trapped in body:
□ General sensation of heaviness in body □ Mental heaviness □ Mental sluggishness
□ Mental fogginess □ Swollen hands □ Swollen feet □ Swollen joints
□ Chest congestion □ Nausea □ Snoring □ Dizziness
□ Snoring □ Phlegm production

Urination:
How many times per day do you urinate?

Do you wake during the night to urinate? How many times per night?

□ Normal color urine □ Dark yellow □ Clear □ Reddish
□ Cloudy □ Scanty □ Profuse □ Strong Odor
□ Burning □ Painful □ Difficult □ Urgent

Libido:
□ Normal □ High □ Low

Men Only:
□Swollen testes □Testicular pain □Impotence □Premature ejaculation
□Feeling of coldness or numbness in external genitalia □Other_____

Women only:
Do you practice birth control? What type and for how long?

Pregnant? □□Y □N Is there a chance you may be pregnant now?

Vaginal discharge: Frequent? Color? Odor?

Regular menstrual cycle?□ □Y □N

Number of children: _____ Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause (if applicable):_____

Average number of days of flow: _____ Average number of days of entire cycle: _____

Uterine bleeding/spotting between periods? □Y □N How much and how often?

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 in the following menstrual chart:

Menstruation	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 (describe size: large, small, black, purple, red, other)							

All please fill out:

Please describe your Average Daily Diet:

Breakfast Lunch Dinner

Snacks (eaten at what time?):

Please tell us of any other problems you would like to discuss: _____

_____

_____

_____

_____

_____

_____

Patient Signature: _____

Acupuncturist Signature: _____