Patient Health History Questionnaire

Welcome to our center! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **Comments** section. Thank you!

Name: Date:

Street: City State Zip

Age: Height: Weight: Email:

Home Phone: Work Phone: Cell Phone:

Date/Place of Birth: Marital Status:

Employer: Title:

In Emergency Notify: Emergency Contact #:

Referred by: Family Physician:

Have you tried acupuncture before?

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES):

- ☐ Allergies:
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic Fever
- ☐ Surgeries
- ☐ HIV
- ☐ Thyroid Disease
- ☐ Birth Trauma (prolonged labor, forceps delivery,etc.)
- ☐ Other significant illness (describe)
- ☐ Accidents or Significant Trauma (describe)

OTHER RELEVANT MEDICAL HISTORY

Patient Information

Back to Health Center
900 Prince Street
Alexandria, Va 22314
703-683-7771

FAMILY MEDICAL HISTORY

☐ Allergies ☐ Cancer ☐ Seizures
☐ Diabetes ☐ Heart Disease ☐ Stroke
☐ Asthma ☐ High Blood Pressure ☐ Other

OCCUPATION

Occupational stress factors (physical, psychological, chemical): ____________________

____

LIFESTYLE

Do you follow a regular exercise program? If so, please describe: ____________________

____

Please describe your average daily diet: ____________________

____

Please check any of the following habits that apply. How much and how often do you use them:

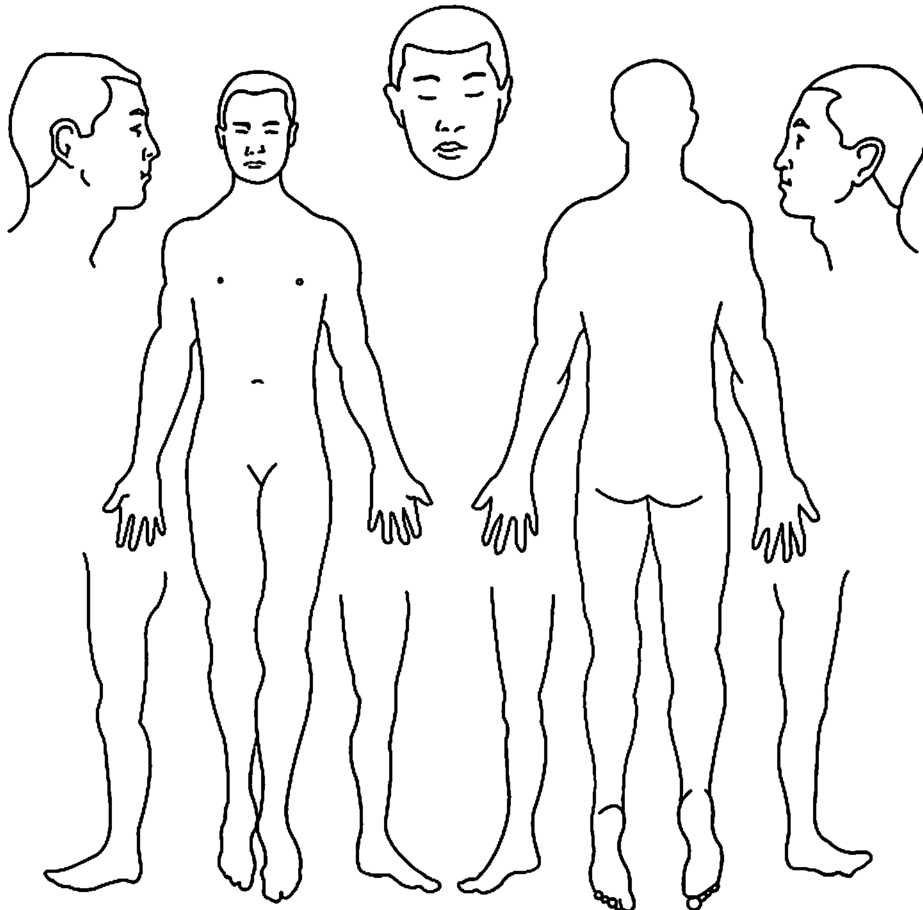
☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.): ____________________

____

Please describe any use of drugs for non-medical purposes: ____________________

PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW



PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day?)
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health ____________________

____

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin problems ____________________

HEAD, EYES, EARS, NOSE, THROAT

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

Any other head or neck problems ____________________

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems ____________________

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung problems ____________________

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

Any other problems with stomach or intestines ______

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate? ______ If so, how often? ______

Any particular color to your urine? ______

Any other genital or urinary problems ______

REPRODUCTIVE AND GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

Age at first menses ______ Age at menopause ______ Number of pregnancies ______

Time between cycles ______ Duration of bleeding ______ First day of last menses ______

Do you practice birth control? ______ If so, what type? ______ For how long? ______

Any other gynecologic problems ______

MUSCULOSKELETAL

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

Any other joint or bone problems ______

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress

Have you ever been treated for emotional problems? ______

Have you ever considered or attempted suicide? ______

Any other neurological or psychological problems ______

COMMENTS

Please list any other problems you would like to discuss: ______

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PATIENT CONFIDENTIALITY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and/or your TCM diagnosis (including treatment, payment and health care operation):____
   ____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name______________________ Phone Number_____________

   Name______________________ Phone Number_____________

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent IF OTHER THAN YOUR HOME:

   Street/P.O. Box ____

   City/State/ZipCode____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   YES_________ NO________

5. Can confidential messages (ie: appointment reminders) be left on your telephone answering machine or voicemail?

   YES_________ NO_________

6. Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information IF OTHER THAN YOUR HOME PHONE NUMBER:_________________________

7. Would you like to receive information about upcoming events, open houses, newsletters and/or other information on Chinese Medicine via email?

   YES_________ Email address:____________________
   NO_________

   PATIENT NAME (please print)______________ ______________

   ___________________________ ______________
   PATIENT/GUARDIAN SIGNATURE DATE