

CONFIDENTIAL

Health Questionnaire

Date _____

Dear Patient:

Please complete this questionnaire. Your answers will help us to determine whether Acupuncture can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Thank you for your cooperation.

Your Name _____
(PLEASE PRINT)

Address _____

Home Phone _____ Work Phone _____

Date of birth _____ Age _____

Male _____ Female _____ M S W D

Chief Complaint _____

Occupation _____

Employed By _____

Social Security No. _____

Referred by _____

★ **HAVE YOU HAD ANY OF THE FOLLOWING?**

	Yes	No
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>
Chorea	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Lumbago	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Mental disorders	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Small pox	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid fever	<input type="checkbox"/>	<input type="checkbox"/>
Venereal infection	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>

★ **ANY FALLS, ACCIDENTS, INJURIES?**

Yes No

If yes, please explain _____

★ **EVER BEEN UNCONSCIOUS?**

Yes No

★ **SURGERY?**

Yes No

If yes, please give kind and date _____

★ **ARE YOU TAKING ANY MEDICATION?**

Yes No

★ **HABITS**

Heavy Moderate Light

Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ **HAVE YOU EVER HAD A NERVOUS BREAKDOWN?** Yes No

★ **HAVE YOU EVER HAD ANY MENTAL DISORDERS?** Yes No

Others in family? Yes No

★ **IS THERE ANY ILLNESS IN YOUR FAMILY?** Yes No

★ **WHAT PREVIOUS TREATMENT HAVE YOU RECEIVED:** _____

★ **HAVE YOU EVER BEEN HOSPITALIZED?**

Yes No If yes, please explain _____

★ **HAVE YOU HAD PREVIOUS ACUPUNCTURE CARE?** Yes No If yes, date of last care _____

★ **HOW LONG HAS IT BEEN SINCE YOU HAVE HAD:**

Complete physical exam _____

Heart exam _____

Blood pressure check _____

★ **DO YOU HAVE HEALTH AND ACCIDENT INSURANCE?** Yes No

If yes, what company? _____

★ **IS THIS AN INDUSTRIAL ACCIDENT CASE?**

Yes No

★ **AUTO ACCIDENT?** Yes No

SYMPTOMS

★ GASTRO-INTESTINAL

★ RESPIRATORY

★ GENERAL

	severe	mild	none
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	severe	mild	none
Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distension of abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids (Piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain over stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting of blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	severe	mild	none
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ MUSCLE & JOINT

Back ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faulty posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful tail bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ CARDIO-VASCULAR

Hardening of arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralytic stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous heart stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid beating heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow beating heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ E.E.N.T.

Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Far sightedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gum trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near sightedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ SKIN

Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives or allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin eruptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ GENITO-URINARY

Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to control urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infection or stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pus in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ FOR WOMEN ONLY

Congested chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps or backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>