

Acupuncture Healing Point
Natalie Miner, L.Ac.
744 San Antonio Road
Palo Alto, CA 94043
408-768-9122
natalie.miner@gmail.com

HEALTH HISTORY QUESTIONNAIRE
Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

1. General Patient Information

Date: ___/___/___

Name: _____

Address: _____

City, State, Postal Code: _____

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

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

Guardian (if under 18): _____

Gender: M F Height: ___' ___" Weight: _____ lbs.

e-mail: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

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

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional: _____

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: _____

Immunizations: _____

Surgeries: _____

III. 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 currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

- Cold hands Afternoon flushes
- Cold fingers Night sweats
- Cold feet Heat in the hands, feet, and chest
- Cold toes Hot flashes any time of the day
- Sweaty hands Thirsty
- Sweaty feet Perspire easily
- Hot body temperature (sensation) Lack of perspiration
- Cold body temperature (sensation) Take water to bed

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

Overall blood (Liver, Spleen, Heart function):

- Dizziness
- See floating black spots

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

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

Heart function:

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

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

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

Eyes (Liver function):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

Libido:

- Normal
- High
- Low

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Painful
- Urgent
- Frequent

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

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? _____)

Women only:

Regular menstrual cycle? Y N

Pregnant? 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: _____

Vaginal discharge

Bleeding between periods

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:

	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:

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: _____