

BEST ACUPUNCTURE
HEALTH HISTORY QUESTIONNAIRE
Information for your Acupuncturist & Team

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

I. General Patient Information

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

Name: Mr./Mrs./Ms. _____

Address: _____

City, State, Zip Code: _____

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

Cell Phone: (_____) _____ Email Address: _____

Circle preferred contact: Home / Cell / Work / Email Place of Birth: _____

Guardian (if under 18): _____

Emergency Contact: (name, relationship & phone) _____

Gender: M F Height: _____' _____" Current Weight: _____ lbs. Ideal Weight: _____ lbs.

Occupation: _____ Employer: _____

How did you hear about Best Acupuncture? _____

Major Complaint(s), in order of significance to you and how long you have been dealing with them:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Additional Info: _____

How do these conditions impair your daily activities? _____

II. Patient Medical History

Childhood Illnesses: _____

Adult Illnesses: _____

Hospital Visits/Stays: _____

Recent tests: (please indicate test results and dates below)

Physical _____ Cholesterol _____ Prostate _____

Pap smear _____ Mammography _____ HIV/STD _____

Blood, which? _____

Other Test Results & Dates: _____

Check the conditions you have or had in the past. Please indicate the year when your symptoms began.

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne _____ | <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Meningitis _____ |
| <input type="checkbox"/> ADD/ADHD _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> Allergies (Soy, nuts, citrus, gluten, latex, dairy, etc) | <input type="checkbox"/> Fever _____ | <input type="checkbox"/> Mononucleosis _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Fibromyalgia _____ | <input type="checkbox"/> Multiple Sclerosis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Hay fever _____ | <input type="checkbox"/> Nervous disorder _____ |
| <input type="checkbox"/> Blood disorder _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Paralysis _____ |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Carpal Tunnel _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Celiac Disease _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Psoriasis _____ |
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> HIV _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Crohn's Disease _____ | <input type="checkbox"/> Interstitial Cystitis _____ | <input type="checkbox"/> Shingles _____ |
| <input type="checkbox"/> CVA/Stroke _____ | <input type="checkbox"/> Irritable Bowel _____ | <input type="checkbox"/> Thyroid disorder _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Jaundice _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Lupus _____ | <input type="checkbox"/> Vein condition _____ |
| <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Measles _____ | |

If you checked the box for allergies, please list what kind: _____

Any other diagnosis/conditions not listed above and date of first symptoms: _____

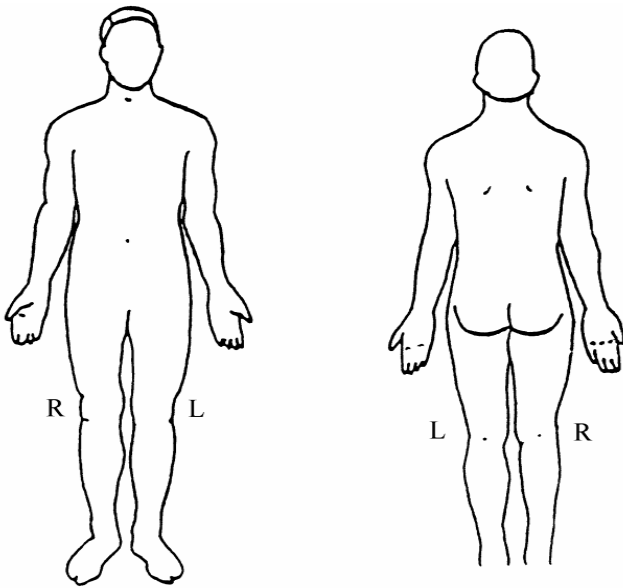
Immunizations: _____

Surgeries & Dates: _____

Have you had any lymph nodes removed? If so, when and where on your body? _____

III. Patient Profile

On the bodies below, please indicate any area of pain you are currently experiencing.



Please also indicate above, in colored ink, any scars from accidents or surgeries.

Is the pain:

Sharp Burning Aching Cramping

Dull Moving Fixed

Other: _____

Do the following improve the pain?

Pressure Cold Heat Exercise

Other: _____

Do the following worsen the pain?

Pressure Cold Heat

Other: _____

IV. Quality of Life

Are you less productive because of your health problems? _____

Do you enjoy your life less because of your health problems? _____

Do you need to take more breaks or naps? _____

Is it harder to focus or concentrate? _____

V. Sleep

Do you have trouble falling asleep? _____

Do you have nights without restful sleep? _____

Do you wake in the middle of the night? How many times per night? _____

Do you have trouble falling back asleep? _____

Do you wake in the middle of the night to urinate? How many times per night? _____

Is there a specific time at night that you awaken? _____

Do you ever awaken earlier than you normally would? _____

Is there anything else affecting your sleep? _____