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? _____

Primary Care Physician/Other:

Name: _____
Address: _____
Phone Number: _____
Specialty: _____

Name: _____
Address: _____
Phone Number: _____
Specialty: _____

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

1. _____
2. _____
3. _____
4. _____

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.

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

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:_____

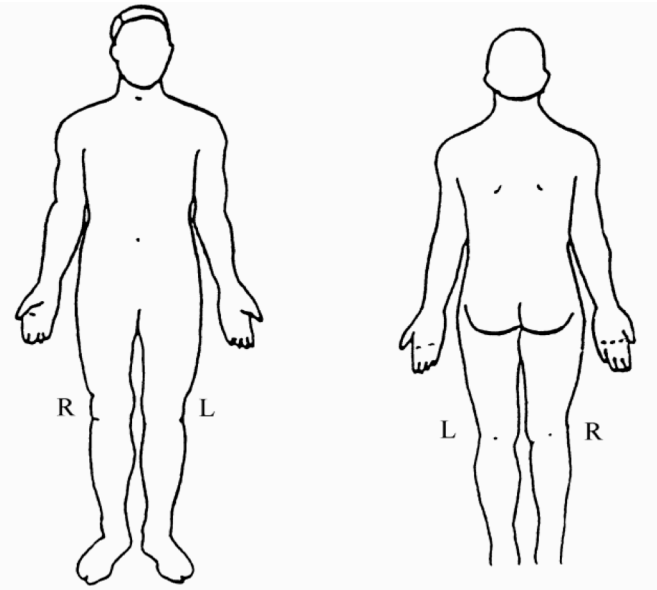
_____

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? _____