Prosperity Health Center
HEALTH HISTORY QUESTIONNAIRE

Important: Complete this document! All information is strictly confidential.
I. GENERAL PATIENT INFORMATION Date: ____/____/_____

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Email address: _____

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

Guardian (if under 18 years of age): _____
Gender: □M □F Height: ____′____″ Weight: _____ lbs. Marital Status: ____

Occupation: _____ Employer: _____
How did you hear about our office? _____

Family Physician: _____ Phone: _____

Insurance Company: _____ Policy #: _____
Emergency Contact Name, Phone Number and Relation to Patient:
Name:
Phone Number:

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No (please circle)
If yes, when was last time and what condition?

Main Conditions you would like us to help you with, in order of significance:

1. 4.

2. 5.

3. 6.

How long ago did these problem(s) begin, please be specific:

To what extent do these problems affect your daily activities, such as work, sleep or hobbies?

What kinds of treatment have you tried, and how have they worked?
Have you been given a diagnosis for any of these problems, if so, what?

II. PAST MEDICAL HISTORY

How was your childhood health?

List all Hospitalizations, Surgeries, Auto Accidents, Trauma, Falls and dates:

Allergies (food, seasonal, medication, environmental):

Recent Tests (Please indicate test results and date):

Physical Cholesterol Prostate Blood (which) HIV/STD

Pap Smear Mammography Other: _____

Significant Test Results and Date: _____

Circle any you have had in the past:

Diabetes	Allergies	Glaucoma	Rheumatic Fever	Heart Disease	CVA (Stroke)
Vein condition	Asthma	Pneumonia	Tuberculosis	Emphysema	Mumps
Jaundice	Gonorrhea	Syphilis	Bleeding Tendency	Measles	High Fever
Meningitis	Chicken Pox	Epilepsy	Nervous Disorder	High Fever	Hepatitis
Mononucleosis	HIV/AIDS	Polio	Thyroid Disorder	Paralysis	Cancer
Migraines	Diabetes	Hepatitis	High Blood Pressure	Lung Disorder	Liver Disorder

Kidney Disorder Spleen Disorder Stomach Disorder

Other: _____

Immunizations:

Family Medical History: Please circle all that apply in your immediate family

Cancer Diabetes High Blood Pressure Stroke Seizures
Allergies

Asthma Heart Disease Other Major Illnesses: _____

III. PATIENT PROFILE

Please list all medications taken in the last 3 months (including drugs, vitamins and herbs):

Occupational Stress (chemical, physical, psychological, etc.):

Do you have a regular exercise program? If yes, describe:

Are you on a restricted diet? If yes, describe:

Do you drink alcohol? How often and how much?

How many caffeinated drinks do you drink per week (coffee, tea, soda)?

Do you smoke? If yes, how many cigarettes per day?

Pain Conditions:
Indicate any areas of pain in the body and the location of any scars on the body:
Is the pain sensation:
Sharp Burning Aching Cramping Dull Moving Fixed
Other:

Do any of the following lessen the pain:
Pressure Cold Heat Exercise Other:
Do any of the following worsen the pain:
Pressure Cold Heat Exercise Other:

Please check the following that pertain to you:

Overall Temperature (Kidney Function):
□ Hot body temperature or sensation □ Cold hands □ Sweaty hands □ PM flushes
□ Cold body temperature of sensation □Cold feet □ Sweaty feet □ Night sweats
□ Heat in the hands, feet and chest □ Hot flashes any time of the day □ Seldom sweats
□ Perspire easily □ Thirsty: for hot or cold drinks

Overall Energy (Lung and Kidney Function):
□ Difficulty keeping eyes open in the daytime □ Shortness of breath □ General weakness
□ Easily catch colds □ Low Energy □ Feel worse after exercise

Overall Blood Function:
□ See floaters or floating black spots in the eyes □ Recent moles, unusual moles
□ Freckles □ Dizziness □ Pimples

Eyes: (Liver Function)
□ Itchy □ Red or Bloodshot □ Hot □ Dry □ Watery □ Gritty or sandy feeling
□ Blurry vision □ Decreased night vision □ Near-sighted □ Far-sighted
□ Cataracts □ Visual Disturbances

Liver and Gallbladder Function:

Chest pains	Tight sensation in chest	Bitter taste in mouth
Anger easily	Frustration	Depression
Irritability	Skin rashes	Tingling sensations
Numbness	Muscle Spasms	Muscle Twitching
Muscle Cramping	Seizures	Convulsions
Lump in throat	Teeth Grinding	Alternating diarrhea and constipation
Neck tension	Shoulder tension	Hip pain/Sciatica

Drink alcohol Recreational drugs (which, how much per week?)
High pitch ringing in the ears Gallstones, history of or currently
Sexually transmitted diseases (which) Genital sores
Frequently unable to adapt to stress (what causes this stress?)
Headaches: How Often? Describe location:
Migraines

Heart Function:

Cardiovascular disease		High blood pressure	Low blood pressure
Chest pain	Fainting	Palpitations	Sores on tip of tongue
Restlessness	Anxiety	Hard to fall asleep	Wake unrefreshed
Nightmares	Restless sleep	Mental Confusion	Restless dreaming

Waking during the night Chest pain traveling to shoulders or down arms

Spleen Function:

Low appetite	Changes in appetite	Cravings, for what?
Abrupt weight gain	Abrupt weight loss	Abdominal bloating
Abdominal gas	Stomach Gurgling	Fatigue after eating
Easily bruised	Hemorrhoids	Pensive/Over-thinking
Worry	Prolapsed organs: which organ?	

Spleen, Stomach, Large Intestine, Small Intestine Function:

Loose Stools	Incomplete Bowel Movements	Constipation
Diarrhea	Blood in Stools	Undigested food in stools
Mucous in stools	Black or tarry stools	Chronic use of laxatives: what type of laxative?

Stomach Function:

Burning sensation after eating	Large appetite	Bad breath	Vomiting
Sores on lips, tongue or mouth	Ulcer (if diagnosed)	Belching	Acid regurgitation
Cold sensation in stomach	Hiccoughs	Stomach Pain	Heartburn
Bleeding, swollen or painful gums			

Lung Function:

Profuse nasal discharge:	thin/clear/runny	thick/white	thick/yellow
Cough: Wet or Dry	Nose Bleeds	Sinus Congestion	Dry mouth
Dry, itchy throat	Sore throat	Dry skin	Allergies: to what?
Sneezing	Hives	Stiff neck	Stiff shoulders
Bronchitis	Rashes	Itching	Eczema
Dandruff	Sadness	Melancholy	Difficulty inhale or exhale

Alternating fever and chills Achy feeling in the body Smoke cigarettes

Kidney, Urinary Bladder Function:

□ Frequent cavities □ Easily Broken Bones □ Poor hearing □ Earaches
□ Painful knees □ Weak knees □ Cold in knees □ Low back pain
□ Memory problems □ Excessive hair loss □ Pre-mature grey hair □ Low-pitch ringing in the ears
□ Kidney stones □ Bladder infections □ Fear □ Easily startled
□ Foot or ankle weakness or pain □ Lack bladder control □ Sneeze or jump incontinence

Dampness trapped in body:

□ General sensation of heaviness in body □ Mental heaviness □ Mental sluggishness
□ Mental fogginess □ Swollen hands □ Swollen feet □ Swollen joints
□ Chest congestion □ Nausea □ Snoring □ Dizziness
□ Snoring □ Phlegm production

Urination:

How many times per day do you urinate?

Do you wake during the night to urinate? How many times per night?

□ Normal color urine □ Dark yellow □ Clear □ Reddish
□ Cloudy □ Scanty □ Profuse □ Strong Odor
□ Burning □ Painful □ Difficult □ Urgent

Libido:

□ Normal □ High □ Low

Men only:

□Swollen testes □Testicular pain □Impotence □Premature ejaculation
□Feeling of coldness or numbness in external genitalia □Other_____

Women only:

Do you practice birth control? What type and for how long?
Pregnant? □□Y □N Is there a chance you may be pregnant now?
Vaginal discharge: Frequent? Color? Odor?

Regular menstrual cycle?□ □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: _____
Uterine bleeding/spotting between periods? □Y □N How much and how often?

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 (describe size: large, small, black, purple, red, other)							

All please fill out:

Please describe your Average Daily Diet:
Breakfast Lunch Dinner

Snacks (eaten at what time?):

Please tell us of any other problems you would like to discuss: _____

_____

_____

_____

_____

_____

_____

Patient Signature: _____

Acupuncturist Signature: _____

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____
Print Name of Patient	Print Name of Acupuncturist
X_____	X_____
Signature of Patient (or Representative)	Signature of Acupuncturist
_____	_____
(Print Name of Patient Representative)	(Print Name of Witness/Translator)
X_____	_____
Date Consent Completed	(Signature of Witness/Translator)