Health History Questionnaire

Please help in providing you with the best care by taking the time to fill out this questionnaire. *All of your answers will be held absolutely confidential.* If you have any questions, please ask. Please include in the "Comments" section anything or any problems that you would like to discuss that are not included in this form.

Date:

Name:	Gender: ☐M ☐F	Age:	Height:	Weight:
Address:		Date of Birth:		
		Place of Birth:		
Home phone:	Cell phone:	Work phone:		
Best number to contact you?	Email:			
Name of emergency contact (local):	Contact phone:	Relationship:		
Occupation:	Physician:			
How did you hear about C. Krieger Acupuncture?				
Have you ever been treated with acupuncture or Oriental medicine before? ☐ Yes ☐ No Where?				
Main problem(s) you would like help with:				
When did the problem(s) begin? Please be specific.				
To what extent does the problem(s) interfere with your daily activities, such as work, sleep, recreation, sex?				
How would you like the problem(s) to change?				
Have you been given a diagnosis for this problem? If so, what?				
What other types of treatment have you tried?				
How would you rate the overall stress level in your life? ☐ Low ☐ Moderate ☐ High Please explain.				
Have you ever served in the military? ☐ Yes ☐ No When and where?				

Medical History

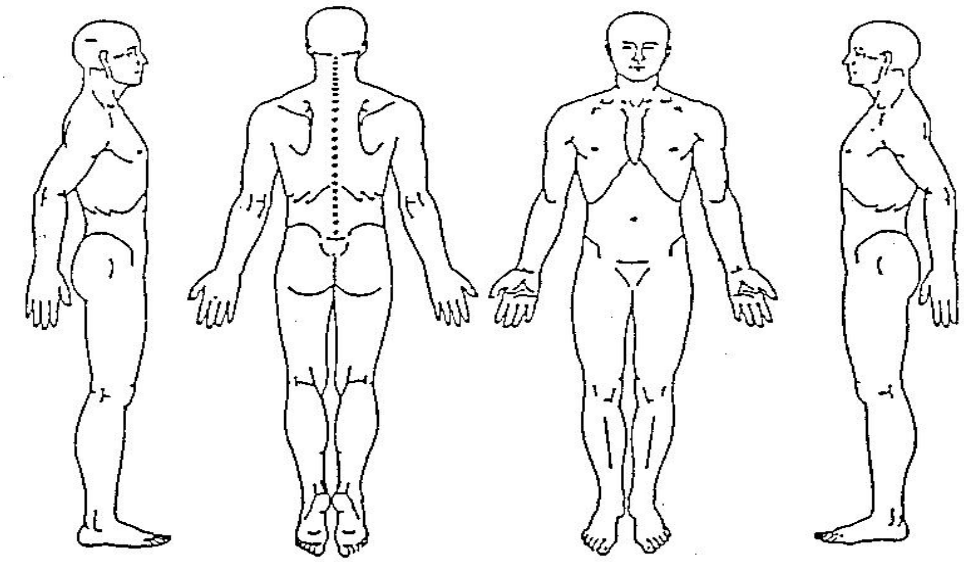
Allergies (drugs, foods, chemical/ environmental):
Medications/ supplements/ vitamins (in the last two months):
Past medical history (including childhood illnesses):
Surgeries/procedures (and dates):

Significant injuries/trauma (auto accidents, falls, etc.):	
Significant diagnoses (please check any that apply):	
☐ Blood disorder/ bleeding problems	☐ Rheumatoid arthritis
☐ Diabetes	☐ Other arthritis
☐ Heart disease	☐ Hepatitis/ liver disease
☐ High blood pressure	☐ HIV/AIDS
☐ Stroke	☐ Tuberculosis
☐ Thyroid problems	☐ Sexually transmitted diseases
☐ Kidney disease	☐ Epilepsy/ seizures
☐ Gastrointestinal problems (reflux, IBD, ulcerative colitis, Crohn's disease)	☐ Neurological disease (multiple sclerosis, Parkinson's disease, etc.)
☐ Respiratory problems	☐ Depression/ other mental illness
☐ Cancer [type(s) and date(s)]:	☐ Chemical dependency (alcohol, drugs)
☐ Other (please describe):	
Family Medical History (please check all applicable) ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Cancer ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Seizures ☐ Thyroid disease ☐ Other:	
Please describe any use of drugs for non-medical purposes.	
Do you have a regular exercise program? ☐ Yes ☐ No (Please describe)	
Do you smoke? ☐ Yes ☐ No If yes, how much?	Do you drink alcoholic beverages? ☐ Yes ☐ No How much per week?
How much fluids (including water) do you drink per day?	
How much caffeinated coffee, tea, colas do you drink per week?	

Please describe your average daily diet

Morning	Afternoon	Evening	Snacks

Please indicate any painful or distressed areas by circling the area.



Name: _____ Date: _____

Please check any symptoms you have had in the past three to six months:

General

- ☐ Feeling hot/ fevers
- ☐ Sweats easily
- ☐ Afternoon / night sweats
- ☐ Feeling cold/ chills
- ☐ Bruise or bleed easily
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Peculiar tastes or smells
- ☐ Fatigue
- ☐ Sudden drop in energy
- ☐ Poor sleep

Skin & Hair

- ☐ Rashes /hives
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems?
- ☐ Ulcerations/ unhealed sores
- ☐ Eczema
- ☐ Loss of hair
- ☐ Warts
- ☐ Pimples
- ☐ Recent moles

Head, eyes, ears, nose and throat

- ☐ Glasses/ contacts
- ☐ Poor vision
- ☐ Cataracts
- ☐ Eye strain
- ☐ Eye pain
- ☐ Color blindness
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Spots/floaters
- ☐ Sensation of something stuck in throat
- ☐ Any other head or neck problems?
- ☐ Poor hearing
- ☐ Ear aches/ pain
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Grinding teeth
- ☐ Gum or teeth problems
- ☐ Sores on lips, gums, tongue
- ☐ Loss of smell/ taste
- ☐ Bitter taste in mouth
- ☐ Recurrent sore throat
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks/ locks
- ☐ Concussions
- ☐ Migraines
- ☐ Headaches (where, when?)

Respiratory

- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough
- ☐ Coughing blood
- ☐ Production of phlegm: ☐ loose ☐ thick/ sticky What color?
- ☐ Any other lung/breathing problems?
- ☐ Asthma
- ☐ Difficulty inhaling/exhaling
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Pain with a deep breath
- ☐ Pulmonary embolism
- ☐ Difficult breathing when lying down

Cardiovascular

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Any other heart or blood vessel problems?
- ☐ Fainting
- ☐ Colds hands or feet
- ☐ Swelling of feet/ legs
- ☐ Swelling of hands
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Varicose /spider veins
- ☐ Peripheral artery disease

Gastrointestinal

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion/ acid reflux
- ☐ Gall stones
- ☐ Abdominal pain or cramps
- ☐ Any other stomach or intestinal problems?
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Diarrhea/ loose stool
- ☐ Undigested food in stool
- ☐ Constipation
- ☐ Blood in stools
- ☐ Black stools
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Incomplete bowel movements

Urinary

☐ Frequent urination ☐ Pain on urination ☐ Kidney stones
☐ Urgent urination ☐ Blood in urine ☐ Falling (prolapsed) bladder
☐ Unable to hold urine ☐ Decrease in urine flow
☐ Do you wake up to urinate? ☐ Yes ☐ No How often?
Urine color: ☐ light or clear ☐ amber ☐ cloudy ☐ other (specify):
☐ Any other problems with your urinary system?

Female reproductive

Are you pregnant? ☐ Yes ☐ No **LMP** Age of first menses: _____
Is it possible you are pregnant? ☐ Yes ☐ No Duration of menses _____
Menopause? Age: Time between of menses: _____
Pregnancies? #_____ Premature births # _____
Live births #_____ Miscarriages #_____

☐ Irregular periods ☐ Vaginal discharge ☐ Infertility
☐ Painful periods ☐ Sores on genitals ☐ Western fertility treatments
☐ Clots ☐ Sexually transmitted disease ☐ Breast lumps
☐ Menstrual flow (heavy / moderate / light)
☐ Premenstrual symptoms?
☐ Do you practice birth control? Type and for how long?
☐ Any other reproductive problems?

Male reproductive

☐ Impotence ☐ Premature ejaculation ☐ Testicular pain/ injury
☐ Prostatitis ☐ Spermatorrhea ☐ Testicular cancer
☐ Prostrate cancer ☐ Low sperm count ☐ Sores on genitals
☐ Enlarged prostrate ☐ Low motility
☐ Any other reproductive problem?

Musculoskeletal

☐ Neck pain ☐ Hip pain ☐ Muscle pain
☐ Shoulder pain ☐ Knee pain ☐ Muscle weakness
☐ Hand/ wrist pain ☐ Foot/ ankle pain ☐ Muscle cramping
☐ Back pain: ☐ upper ☐ middle ☐ lower
☐ Any other muscle, joint or bone problems?

Neurological

☐ Seizures ☐ Dizziness ☐ Areas of numbness
☐ Stroke ☐ Loss of balance ☐ Poor memory
☐ Concussion ☐ Lack of coordination ☐ Tremors (where?)
☐ Any other neurological problems?

Psychological

☐ Depression ☐ Easily angered ☐ ADD/ ADHD
☐ Anxiety ☐ Easily susceptible to stress ☐ Bipolar disorder
☐ Panic attacks ☐ Easily over worried ☐ Post-traumatic stress
☐ Poor concentration ☐ Seasonal affective disorder disorder (PTSD)
Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other psychological problems?

Comments: (Is there anything else about your health you would like to discuss?)