Abundant Life Acupuncture

Health History Questionnaire

Date:___/_____/_____

Patient's Name (Last, First, M.I.)	**DOB** (mm/dd/yyyy) **Sex** (M/F)		**Patient Status:** Single ☐ Married ☐ Other ☐ Employed ☐ Student: F-Time ☐ P-Time ☐
Patient's Address (No, Street)	**Relation to Insured**		**Patient's Employer**
City **State**	**Zip Code**	**Phone** (10 digit)	**Patient's Insurance ID#**
Insured's Name (Last, First, M.I.)	**DOB** (mm/dd/yyyy) **Sex** (M/F)		**Insured's Insurance #**
Insured's Address (No, Street)	**Phone** (10 digit)		**Insured's Employer**
City **State**	**Zip Code**	**PIP/Auto Claim #**	**Group ID #**

Insurance Company			**Plan Name or Program**	
Billing Address			**Telephone/Adjuster's Contact Info:**	
Onset/Injury Date	**Auto Accident (Y/N)**	**U.S. State**	**Work related (Y/N)**	**Other Accident (Y/N)**

Who should we thank for referring you? _____

Main problem you would like help with: _____
_____
_____

When did the problem begin (please be specific) _____
_____

What do you think caused it? Is the cause still present? _____
_____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____
_____
_____

Have you been given a diagnosis for the problem? If so, what? _____
_____

What treatments have you tried already? What were the results? _____
_____
_____

How severe is your problem right now? (Please mark the scale below)
I_____I_____I
No problem Moderate Worst Imaginable

What's the most severe level you have endured over the past week? (Please mark the scale below)
I_____I_____I
No problem Moderate Worst Imaginable

Patient Name_____ Date_____

Past Medical History (please indicate by dates):

Cancer: _____	HIV/AIDS: _____	Thyroid Disease: _____	Asthma_____
Diabetes: _____	High Blood Pressure: _____	Rheumatic Fever: _____	Seizures_____
Hepatitis: _____	Heart Disease: _____	Venereal Disease: _____	Stroke_____

Surgeries (types & dates):_____
_____

Significant Traumas: (auto accidents, falls etc,) _____
_____

Significant Dental Work: _____
_____

Allergies (drugs, chemicals, foods, etc.) _____
_____

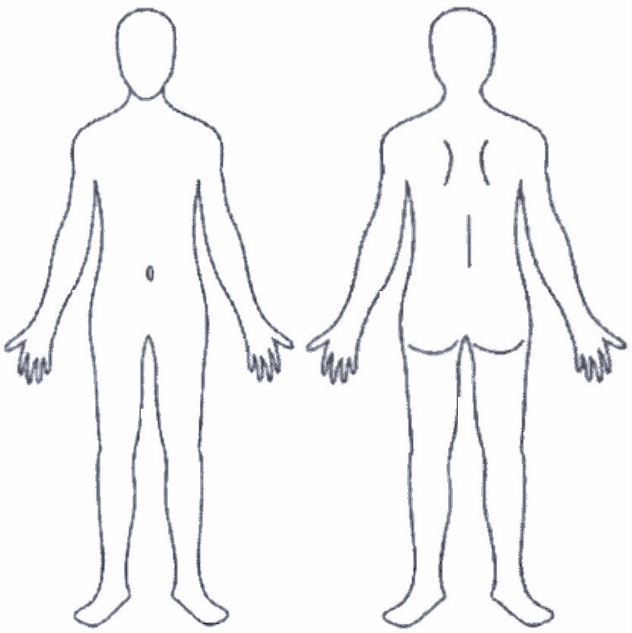
Occupational Stress (chemical, physical, psychological) _____
_____

Birth History (prolonged labor, forceps, premature, etc.) _____
_____

Family Medical History

☐ Cancer	☐ Heart Disease	☐ Asthma
☐ Diabetes	☐ Stroke	☐ Allergies
☐ High Blood Pressure	☐ Seizures	☐ Other _____

Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- ☐ Temporary relief of the symptoms/pain control
- ☐ Eliminate root or cause of problem (if possible)
- ☐ Lessen/eliminate habits which caused the condition or made it worse
- ☐ Maintenance care (periodic balancing/tune-up to keep in good health)

Patient Name_____ Date_____

Please check any boxes of symptoms you have had in the past month.

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night Sweats
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes/ smells
- ☐ Strong thirst (cold/hot)
- ☐ Thirst/no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drops

*Time of day*_____

- ☐ Poor Sleep
- ☐ Recurrent Infections
- ☐ Cravings
- ☐ Edema

*Where:*_____

- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change

*Gain/Loss*_____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Hives
- ☐ Oozing/Ulcerations
- ☐ Pimples
- ☐ Dry skin / scalp
- ☐ Recent moles
- ☐ Changes in hair/skin

Other _____

Head, Eyes, Ears, Nose and Throat

- ☐ Headaches

Where _____
When _____

- ☐ Migraines
- ☐ Dizziness
- ☐ Discharge from ear
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Blurry vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Spots in front of eyes
- ☐ Eye Pain
- ☐ Excessive Tearing
- ☐ Eye Dryness
- ☐ Glasses
- ☐ Discharge from eyes
- ☐ Facial Pain
- ☐ Nose bleeds
- ☐ Nasal discharge
- ☐ Sinus congestion
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Recurrent sore throat
- ☐ Hoarseness
- ☐ Sores on lips/tongue
- ☐ Swollen glands

Other _____

Cardio vascular

- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest discomfort/pain
- ☐ Heart Palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands/ feet
- ☐ Blood Clots
- ☐ Spider veins
- ☐ Fainting
- ☐ Difficulty in breathing

Other _____

Respiratory

- ☐ Cough
- ☐ Asthma/Wheezing
- ☐ Shallow breathing
- ☐ Shortness of breath
- ☐ Production of phlegm

Color _____

- ☐ Bronchitis
- ☐ Pneumonia

Other _____

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids

*Other*_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Dribbling urination
- ☐ Prostate problems
- ☐ Impotency
- ☐ Hernia
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Changes in libido

Do you wake at night to urinate?

☐ Yes ☐ No

*How often?*_____
What color is your urine?
_____
*Other*_____

Gynecology

#of pregnancies:_____
#of births:_____
premature births:_____
miscarriages:_____
of abortions:_____
Age at first menses:_____
Length of full cycle:_____
Length of menses:_____
Last menses start date:
_____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ PMS
- ☐ Clots
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Infertility
- ☐ Vaginal discharge
- ☐ Menopause

*Age:*_____

- ☐ Postcoital bleeding
- ☐ Vaginal sores/dryness
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?

☐ Yes ☐ No

What type and for how long?
_____
Are you pregnant now?

☐ Yes ☐ No

Other_____

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Shoulder pain
- ☐ Elbow/Forearm pain
- ☐ Hand/Wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/Ankle pain
- ☐ Muscle pain/weakness
- ☐ Torn tissues

*Other*_____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Muscle weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Bad temper
- ☐ Vertigo
- ☐ Tremors
- ☐ Poor Balance
- ☐ Lack of Coordination
- ☐ Depression
- ☐ Easily stressed
- ☐ Poor memory/focus
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?

☐ Yes ☐ No

Patient Name_____ Date_____

Last Physical

Date:_____ Doctor:_____ Results:_____

_____

Habits

Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant.

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	_____
Coffee:	☐	☐	☐	☐	_____
Tea:	☐	☐	☐	☐	_____
Tobacco:	☐	☐	☐	☐	_____
Exercise:	☐	☐	☐	☐	_____
Sleep:	☐	☐	☐	☐	_____
Appetite:	☐	☐	☐	☐	_____
Energy Level:	☐	☐	☐	☐	_____
Medication:	☐	☐	☐	☐	_____
Vitamins:	☐	☐	☐	☐	_____
Food Intake:	☐	☐	☐	☐	_____
Drugs:	☐	☐	☐	☐	_____
Salt Intake:	☐	☐	☐	☐	_____
Stress Level:	☐	☐	☐	☐	_____
Other:	☐	☐	☐	☐	_____

Diet

Please describe your average daily diet:
Morning: _____
Afternoon: _____
Evening: _____

Are you or have you been on a restricted diet? Please describe the diet and give start/stop dates? _____
_____

Do you have any known food allergies? _____
_____

Medications

What medications and/or supplements are you currently taking? _____
_____
_____
_____

Have you had any courses of antibiotics recently? ☐ Many ☐ A few ☐ 1 or 2 ☐ None