Acupuncture & Oriental Medicine
SEATTLE HEALTH THERAPIES

Health History Questionnaire

Email Address: ________________________ Date_____/_____/_____

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please not it in the ***Comments Section*** on page 4. Thank you.

Name:		Social Security Number:	
Address:	City:	State:	Zip Code:
Home Phone: ( ) -	Work Phone: ( ) -	Sex: ☐ Male ☐ Female	Age:
Date of Birth: _____/_____/_____	City of Birth:	State of Birth:	
Height: ____'____" Weight:	Ethnic Background (check one): ☐ Caucasian/White ☐ African American/Black ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ Hispanic (any race) ☐ Other, Please Specify:______________________		
Employer Name:			
Occupation:	Marital Status(check one): ☐ Never Married ☐ Separated ☐ Married ☐ Living with Partner, Unmarried ☐ Divorced ☐ Widowed		
Family Physician:			
Referred By:	Emergency Contact Phone: ( ) -	Have you been treated by acupuncture or oriental medicine before? ☐ Yes ☐ No	
Emergency, Contact (Name):			

What is/are the main problem(s) you would like us to help you with:
____
____
____

How long ago did this problem begin (be specific):
____
____
____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?
____
____
____

Have you been given a diagnosis for this problem? If so, what?
____
____

What kinds of treatment have you tried?:
____
____

Past Medical History: (please include date)

Cancer______________ High Blood Pressure___________ Thyroid Disease___________
Diabetes_____________ Heart Disease____________ Seizures__________________
Hepatitis______________ Rheumatic Fever___________ Venereal Disease____________
Other:____

Surgeries (type of and date):

____

____

Significant Trauma (auto accidents, falls etc.):

____

____

Significant Dental Work (type and date):

____

____

Birth History (prolonged labor, forceps delivery, etc.):

____

____

Allergies (drugs, chemicals, foods/result):

____

____

Family Medical (check):

☐ Diabetes ☐ High Blood Pressure ☐ Stroke

☐ Asthma ☐ Cancer ☐ Heart Disease

☐ Seizures ☐ Allergies

☐ Other:____

Medicines taken within the last two months (vitamins, drugs, herbs, etc):

____

____

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

____

____

Do you have a regular exercise program? ☐ Yes ☐ No
Please describe:

____

____

Have you ever been on a restricted diet? ☐ Yes ☐ No
What kind:

____

____

Please Describe Your Average Daily Diet

Morning____

Afternoon____

Evening____

How many packs of cigarettes do you smoke per day?

____

How much coffee, tea or cola do you drink per week?

____

How much alcohol do you drink per week?

____

Please describe any use of drugs for non-medical purposes?

____

Please Check Any Symptoms You Have Had in the Last Three Months

General

☐ Chills
☐ Fevers
☐ Sweat easily
☐ Night sweats

☐ Earaches
☐ Discharge from ear
☐ Nose bleeds
☐ Sinus congestion
☐ Nasal drainage

Genitourinary

☐ Pain on urination
☐ Urgency to urinate
☐ Frequent urination
☐ Blood in urine

☐ Localized Weakness
☐ Bleed or bruise easily
☐ Peculiar tastes or smells
☐ Strong thirst (cold or hot)
☐ Thirst, no desire to drink
☐ Fatigue
☐ Sudden energy drop Time of day?
☐ Edema Where: ______________
☐ Poor sleeping
☐ Tremors
☐ Poor balance
☐ Cravings
☐ Change in appetite
☐ Poor appetite
☐ Weight gain
☐ Weight loss

Skin and Hair

☐ Rashes
☐ Itching
☐ Change in hair or skin
☐ Ulcerations
☐ Eczema
☐ Oozing on skin lesion
☐ Hives
☐ Pimples
☐ Recent moles
☐ Loss of hair
☐ Dandruff

Other hair or skin problems:

____

Head, Eyes, Ears, Nose and Throat

☐ Dizziness
☐ Migraines
☐ Headaches:
When: ______________
Where: ______________
☐ Facial pain
☐ Glasses
☐ Poor Vision
☐ Night blindness
☐ Blurry vision
☐ Color blindness
☐ Blind field
☐ Spots in front of eyes
☐ Eye Pain
☐ Eye Strain
☐ Cataracts
☐ Eye dryness
☐ Excessive tear
☐ Discharge from eyes
☐ Poor hearing
☐ Ringing in ears
☐ Grinding teeth
☐ Teeth problems
☐ Jaw clicks
☐ Concussions
☐ Recurrent sore throats
☐ Hoarseness
☐ Sores on lips or tongue

Other head or neck problems:

____

Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Sores on lips or tongue
☐ Chest discomfort/pain
☐ Heart Palpitations
☐ Cold hands or feet
☐ Swelling of hands
☐ Swelling of feet
☐ Blood clots
☐ Fainting
☐ Difficulty in breathing

Other heart or blood vessel problems:

____

Respiratory

☐ Cough
☐ Asthma/wheezing
☐ Pain with a deep breath
☐ Difficulty n breathing when lying down
☐ Production of phlegm. What color?_______
☐ Coughing blood
☐ Pneumonia
☐ Bronchitis

Other lung problems:

____

Gastrointestinal

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

Other stomach or intestinal problems:

____

☐ Decrease in flow
☐ Unable to hold urine
☐ Dribbling
☐ Kidney stones
☐ Impotency
☐ Change of sexual drive
☐ Sores on genitals

Do you wake up to urinate? ☐ Yes ☐ No
How often? ______________
Any particular color to your urine?
Other genital or urinary system problems?

____

Pregnancy And Gynecology

Number of pregnancies: __________
Number of births: __________
Number of premature births: __________
Number of miscarriages: __________
Number of abortions: __________
Age at first menses: __________
Period between menses (days): __________
Duration of menses (days): __________
First date of last menses: __________
☐ Heavy periods
☐ Light periods
☐ Painful periods
☐ Irregular periods
☐ Changes in body/psyche prior to menstruation
☐ Clots
☐ Menopause:
Age: ______
Year: ______
☐ Vaginal discharge
☐ Postcoital bleeding
☐ Vaginal sores
Date of Last pap: ______________
☐ Breast lumps
☐ Nipple discharge

Do you practice birth control? ______________
What type and for how long? ______________

____

____

Musculoskeletal

☐ Neck pain
☐ Shoulder pain
☐ Back pain
☐ Elbow pain
☐ Hand/wrist pain
☐ Hip pain
☐ Knee pain
☐ Foot/ankle pain
☐ Muscle pain
☐ Muscle weakness

Neuropsychological

☐ Seizures
☐ Areas of numbness
☐ Weakness
☐ Sleep disorder
☐ Concussion
☐ Vertigo
☐ Lack of coordination
☐ Depression
☐ Easily susceptible to stress
☐ Loss of balance
☐ Poor memory

Have you ever been treated for emotional problems? ☐ Yes ☐ No
Have you ever considered or attempted suicide? ☐ Yes ☐ No
Other neurological or psychological problems

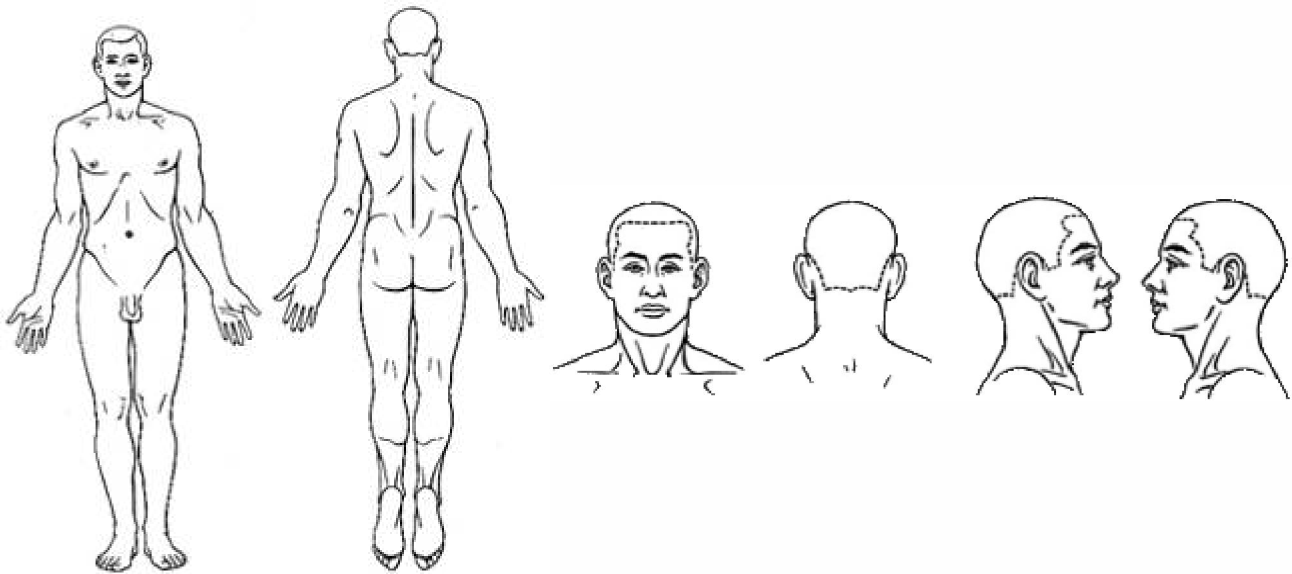
____
____
____

☐ Bad temper
☐ Loss of control/violence potential
☐ Anxiety
☐ Substance abuse
____
____

Please note the degree of severity of your problem now:

Please note the great degree of severity of your problem within the last week:

Indicate painful or distressed areas:



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