Patient Contact Information

Name:____ Date:________________

Address:______________________________________ City, State & Zip:__________________

Primary Phone:____________________________ □ Home □ Cell □ Work

Alternative Phone:____________________________ □ Home □ Cell □ Work

E-mail Address:_________________________________

Preferred Method of Contact: □ Phone □ E-mail

Would you like to receive e-mail appointment reminders? □ Yes, please □ No, thank you

Would you like to receive occasional e-mail newsletters for great recipes, articles, and other news? □ Yes, please □ No, thank you

How did you hear about Holden Acupuncture? ____

Health History Questionnaire

Name: _____________________________ **Date of Birth:** ___________ **Today's Date:** _______________

Gender: □Male □Female **Marital Status:** □Single □Married **Weight:** ______

Occupation: ___________________________ **Primary Care Physician:** ___________________________

Primary Complaint

What has brought you to acupuncture and/or Chinese herbal medicine, today?

____

____

How long ago did this problem start? ____

My symptoms are <u>better</u> with (circle/check all that apply):

□ Applying Cold □ Applying Heat □ Movement □ Pressure □ Rest □ Exercise □ Warm Weather

□ Cold Weather □ Dry Weather □ After Bowel Movements □ Before Bowel Movements

If related to menses, my symptoms are better: □ Before □ During □ After

Does anything else improve your condition? If so, what? ____

My symptoms are <u>worse</u> with (circle/check all that apply):

□ Applying Cold □ Applying Heat □ Movement □ Pressure □ Rest □ Exercise □ Warm Weather

□ Cold Weather □ Dry Weather □ After Bowel Movements □ Before Bowel Movements

If related to menses, my symptoms are worse: □ Before □ During □ After

Specific foods:____

Does anything else worsen your condition? If so, what? ____

If pain is your primary complaint, the pain feels (circle/check all that apply):

□ Dull □ Sharp □ Bloating □ Throbbing □ Achy □ Stabbing □ Moving □ Vice-like

□ Heavy □ Fixed □ Colicky □ Radiates to:______________________

Does your condition limit your daily activities or range of motion? If so, please indicate how:

____

____

Goals

What are your goals for treatment? ____

____

In what ways has your condition actually improved certain aspects of your life? (Please give this question serious consideration) ____

____

Vocation

What is your current job? _______________________________________

How long have you worked there? ____________________

Do you enjoy your current job? □Yes □No □So-So

What do you like most about it? ____

What do you like the least about it? _____________________________________

During the work day, do you do any of the following on a frequent basis? (Circle/Check all that apply)

□ Standing □ Sitting □ Typing □ Unusual posture (please describe):___________________________

Medications & Supplements

Please list all medications, supplements and/or herbs you are currently taking:

Medication	Dosage	Reason for Taking

Are you on any blood thinners (including aspirin)? □ Yes □ No

Please list all allergens to which you react: ____

Hospitalizations/Surgeries

Please list all surgeries, major injuries, inpatient and/or outpatient medical treatment you have had (including dates): ____

____

____

I have had a previous medical diagnosis of (circle/check all that apply):

□ Cancer □ Diabetes □ High Blood Pressure □ Heart Disease □ Seizures □ High Cholesterol

□ Autoimmune Disease □ Thyroid Disease □ Other: _____________________________

Family History

Has anyone in your family complained of this same issue? □ Yes □ No

Has anyone in your family suffered from (circle/check all that apply):

□ Cancer □ Diabetes □ High Blood Pressure □ Heart Disease □ Seizures □ High Cholesterol

□ Autoimmune Disease □ Thyroid Disease

Lifestyle

Do you smoke? □ Yes □ No If yes, how many cigarettes or cigars per day? ______

How many cups of caffeinated coffee do you drink daily? _______ small/medium/large?

How many cups of other caffeinated beverages do you drink daily? _____________

How many alcoholic beverages do you drink per week? ___________ beer/hard alcohol/wine?

Do you have a regular exercise program? □ Yes □ No If yes, please describe: _________________________

____

Please describe any use of non-medicinal drugs: ____

Please describe your typical daily diet, including snacks:

Morning: ____

Afternoon: ____

Evening: ____

Dramatic changes in weight over the last year? □ Yes □ No

Weather

What is your favorite season? □ Winter □ Spring □ Summer □ Autumn □ All

Why is it your favorite? ____

In which season is your condition worse? □ Winter □ Spring □ Summer □ Autumn □ All

In the following sections, please circle or check all that apply.

Skin

I tend to: □ sweat easily □ sweat at night □ not sweat, even with exertion

Skin issues: □ Dry skin □ Frequent rashes □ Eczema □ Psoriasis □ Rosacea □ Hives

Do you bruise easily? □ Yes □ No

Do your bruises take a long time to heal? □ Yes □ No

Hot & Cold

I tend to: □ prefer warm drinks □ prefer cold drinks □ have cold feet/hands

I am overall (circle/check one): □ warmer than other people □ colder than other people

Head

□ Sinus congestion □ Sinus pain/headaches □ Runny nose □ Post-nasal drip

□ Respiratory allergies (circle/check one): □ Seasonal □ Year round

□ **Headaches**: Location: ______________________

How many days out of the month do you have headaches? _____________

Quality of pain (circle/check all that apply): □ Moving □ Fixed □ Stabbing □ Dull

□ Heavy □ Throbbing □ Squeezing

□ **Dizziness:** How many days out of the month do you experience dizziness? ________________

Typical duration of dizzy spells: ____________________

Ears

Discomfort: □ Pain in ear □ Pain around ear □ Feel fluid in ear □ Feel pressure in ear

Ringing: □ High pitched □ Low pitched □ Various pitches

Other: □ Decrease in hearing

Eyes

Irritation: □ Dry eyes □ Itchy eyes □ Conjunctivitis □ Bloodshot

Pain: □ Side of eye □ By nose □ Above eye □ Below eye □ Inside eye socket

Other: □ Blurred vision □ Copious discharge □ Many floaters □ Visual hallucinations

□ Decreased visual acuity □ Eye twitching

Mouth/Throat

Taste in mouth: □ Sour □ Bitter □ Metallic □ Salty □ Sweet □ Spicy □ Decreased sense of taste

Tongue feels: □ Stiff □ Hot/Burning

Other: □ Dry mouth/throat □ Feeling of pit stuck in throat □ Cold sores □ Canker sores □ Tongue pain

Chest

Breathing: □ Short of breath □ Difficulty catching breath □ Frequent sighing □ Tightness in chest

□ Chest heaviness □ Rib pain

Heart: □ Skips beats □ Rapid beating □ Palpitations □ Pain

Cough: □ Dry □ With phlegm: □ Clear □ Watery □ Thick □ White □ Yellow □ Brown

Abdomen

Bloating: □ Just below ribs □ Middle of abdomen □ Below belly button

Pressure makes it: □ Better □ Worse

Sensation: □ Acid reflux □ Burping □ Flatulence □ Nausea □ Vomiting

Vomiting: □ Dry heaves □ Bile taste □ Immediately after eating food □ After cold foods □ Blood

Other: □ Heaviness or sinking feeling in lower abdomen □ Feels like food is stuck in abdomen

Appetite: □ Low appetite □ Always hungry □ Gnawing sensation

Thirst: □ No thirst □ Frequent thirst □ Thirsty, but with no desire to actually drink

Cravings: □ Salty □ Sweet □ Spicy/Hot □ Bitter □ Sour □ Greasy/Fried □ Chocolate

Men & Women

Sexual energy: □ Very high □ High □ Medium □ Low □ Very low

Other: □ Impotence □ Infertility □ Wet dreams □ Premature ejaculation □ Low sperm count

□ Spermatorrhea □ Genital warts □ Genital itchiness □ Difficulty reaching orgasm □ Genital pain

□ Pain during sex

Urine

Frequency: □ Less than every hour □ Hourly □ Every few hours

Sensation: □ Burning □ Dribbling □ Pain □ Difficulty initiating □ Radiating pain to: _______________

Color: □ Clear □ Yellow □ Reddish/Purplish tint □ Cloudy □ Spermatorrhea □ See blood

Discomfort: □ Urgency □ Incontinence □ Bed wetting □ Pass sand or stones

Bowels

Frequency: □ 2x or more/day □ 1x/day □ Every other day □ Less than 3x/week

Color: □ Light brown □ Dark brown □ Tarry □ Black □ Other color: _____________

Sensation: □ Difficult evacuation □ Hemorrhoids □ Intestinal spasm □ Incontinence □ Burning □ Pain □ Fissures

Other: □ See undigested food □ See mucus □ Particularly foul smell □ See blood

Musculoskeletal

Please list aches and pains not indicated as your primary complaint.

Pain location: □ Fingers □ Hands □ Wrists □ Elbow □ Arms □ Neck □ Head □ Face □ Shoulders □ Chest □ Abdomen □ Hips □ Back □ Inguinal □ Legs □ Knees □ Ankles □ Feet □ Toes

Pain: □ Fixed □ Moves around □ Better with cold □ Better with heat

Worse with: □ Cold □ Hot □ Damp □ Pressure □ Movement

Better with: □ Cold □ Hot □ Damp □ Pressure □ Movement

Arms: □ Weakness □ Heaviness □ Easily fatigued □ Joint pain

Legs: □ Weakness □ Heaviness □ Easily fatigued □ Joint pain

Energy

General: □ I awake rested □ I awake tired □ Fatigue after exercise or activity □ Fatigue after meals

□ Fatigue after sex □ Fatigue same time(s) of the day: ______am/pm ______am/pm

Scale: On a scale of 1-10 (10 = highest) what is your energy like on average? __________

Sleep

How many hours do you sleep at night? ________

Do you feel you get enough sleep? □ Yes □ No

Generally I: □ sleep well □ awake frequently □ am a light sleeper □ have difficulty falling asleep

□ have difficulty falling back asleep once awake □ have an active mind □ am kept awake with worry

□ have restless sleep □ have vivid dreams □ have frequent nightmares

How many times per night do you wake to urinate? ___________

Emotions

My strongest emotion(s): □ Grief □ Joy □ Anger □ Worry □ Fear □ Guilt □ Depression

□ Other: ________________

I have trouble experiencing: □ Grief □ Joy □ Anger □ Worry □ Fear □ Guilt □ Other: ____________

I have experienced trauma which continues to affect me: □ Yes □ No

I currently have suicidal thoughts: □ Yes □ No

If yes, I have made a plan to kill myself: □ Yes □ No

I am currently under psychological care: □ Yes □ No

OB/GYN

Age at first menstruation: _______ **Age when menopause began (if applicable):** _______

Total # of days in cycle: ________ **Number of days you bleed:** ________

Number of pregnancies: ________ **Number of live births:** ________ **Number of miscarriages:** _________

Date of last menstrual cycle: __________

Cramping: □ Before bleeding □ At onset □ During □ After

Cramp pain: □ Better with pressure □ Worse with pressure □ Heat improves □ Cold improves

□ Improves with passing of clots

Blood color: □ Bright red □ Dark red □ Pink □ Purplish □ Brown

Consistency: □ Watery □ Copious □ Scanty □ Thick □ Small clots □ Large clots □ See mucus

Other: □ Breast pain □ Irritability □ Nausea □ Vomiting □ Vaginal dryness □ Spotting

Vaginal discharge: □ Thin □ Thick □ White □ Yellow □ Strong odor