Date:

Dancing Turtle Acupuncture

Health History Questionnaire

Please take time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have questions, please ask.

Full Name:					Phone:	
Address:			City:	State:	ZIP:	
Gender:	Age:	Date of Birth:	Place of Birth:		Height:	Weight
Marital Status: ☐ Never Married ☐ Separated ☐ Divorced ☐ Married ☐ Living with Partner ☐ Widowed			Email:			
Employer Name:			Occupation:			
Education: (Highest Level Achieved) ☐ Grade School or Less ☐ Some High School ☐ High School Graduate ☐ Vocational or Technical School ☐ Some College ☐ College Graduate ☐ Graduate or Professional School						
Family Physician:			Referred By:			
Emergency Contact:			Emergency Contact Phone:			
Have you been treated by Acupuncture or Oriental Medicine before? ☐ Yes ☐ No						

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

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

Was there a known cause/instigating factor for your problem?:

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: _____ ☐ Diabetes: _____ ☐ Hepatitis: _____ ☐ Other: _____
- ☐ High Blood Pressure: _____ ☐ Heart Disease: _____ ☐ Rheumatic Fever: _____
- ☐ Thyroid Disease: _____ ☐ Seizures: _____ ☐ Venereal Disease: _____

Family Medical History:

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

Surgeries (Type and Date):

Significant Trauma (Auto Accidents, Falls, etc):

Significant Dental Work (Type and Date):

Allergies (Drugs, Chemicals, Food/Result):

Medicines Taken Within the Last Two Months (Vitamins, Drugs, Herbs, etc.):

Occupational Stress (Chemical, Physical, Psychological, etc):

Do You Have a Regular Exercise Program (Description if yes)?

Have You Ever Been on a Restricted Diet (What kind if yes)?

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: _____

_____

Symptoms

(Circle or Highlight any symptoms that have been persistent in the last three months)

General

Chills Fever Localized Weakness Peculiar Taste or Smells Thirst, no desire to drink Poor Sleeping

Night Sweats Sweat Easily Bleed or Bruise Easily Strong Thirst (Cold or Hot) Fatigue Sudden Energy Drop Time?_____

Edema Where?_____ Tremors Poor Balance

Weight Gain Cravings Weight Loss Change in Appetite Poor Appetite

Skin and Hair

Rashes Change in Hair or Skin Recent Moles Loss of Hair Dandruff Pimples

Itching Oozing on Skin Lesion Ulcerations Hives Eczema

Other Hair or Skin Problems? _____

Head, Eyes, Ears, Nose, and Throat

Dizziness Facial Pain Poor Vision Blurry Vision Blind Field Eye Pain Eye Strain Nose Bleeds

Migraines Glasses Night Blindness Color Blindness Spots in front of Eyes Cataracts Earaches

Sinus Congestion Poor Hearing Ringing in Ears Jaw Clicks Eye Dryness Sores on Lips or Tongue

Discharge from Ear Grinding Teeth Excessive Tear Teeth Problems Hoarseness

Nasal Drainage Recurrent Sore Throats Concussions Headaches When?_____ Where?_____

Other Head or Neck Problems? _____

Cardiovascular

High Blood Pressure Low Blood Pressure Chest Discomfort/Pain Heart Palpitations Cold Hands or Feet

Swelling of Hands Swelling of Feet Fainting Blood Clots Difficulty in Breathing

Other Heart or Blood Vessel Problems? _____

Respiratory

Cough Asthma/Wheezing Pain with a Deep Breath Difficulty in Breathing When Lying Down Coughing Blood Pneumonia

Bronchitis

Other Lung Problems? _____ Production of phlegm What color?_____

Gastrointestinal

Bad Breath Nausea Vomiting Heartburn Belching Indigestion Diarrhea

Chronic Laxative Use Blood in Stools Black Stools Rectal Pain Gas Constipation

Abdominal Pain or Cramps Hemorrhoids Other Stomach or Intestinal Problems? _____

Genito-Urinary

Urgency to Urinate Kidney Stones Frequent Urination Blood in Urine Decrease in Flow

Dribbling Pain Upon Urination Impotency Change of Sexual Drive Unable to Hold Urine

Sores on Genitals Other Genital or Urinary System Problems? _____

Do You Wake Up to Urinate? How Often? _____

Any Particular Color to Your Urine? _____

Pregnancy and Gynecology

Number of Pregnancies _____ Last Pap _____

Number of Births _____ Unusual Character-Heavy

Premature Births _____

Miscarriages _____ Unusual Character-Light

Abortions _____ Changes in Body/Psyche prior to menstruation

Age at First Menses _____

Period Between Menses _____ Vaginal Discharge

Duration _____ Postcoital Bleeding

First Date of Last Menses _____ Vaginal Sores

Menopause (Age and Year) Breast Lumps

_____

Birth Control (What Kind): Clots

_____ Nipple Discharge

Musculoskeletal

Neck Pain Muscle Pain Muscle Weakness

Shoulder Pain Back Pain Elbow Pain Hip Pain

Hand/Wrist Pains Knee Pain Foot/Ankle Pain

Neuropsychological

Seizures Areas of Numbness Weakness Sleep Disorder

Concussion Bad Temper Vertigo Depression Anxiety

Loss of Control Violence Potential Lack of Coordination Poor Memory

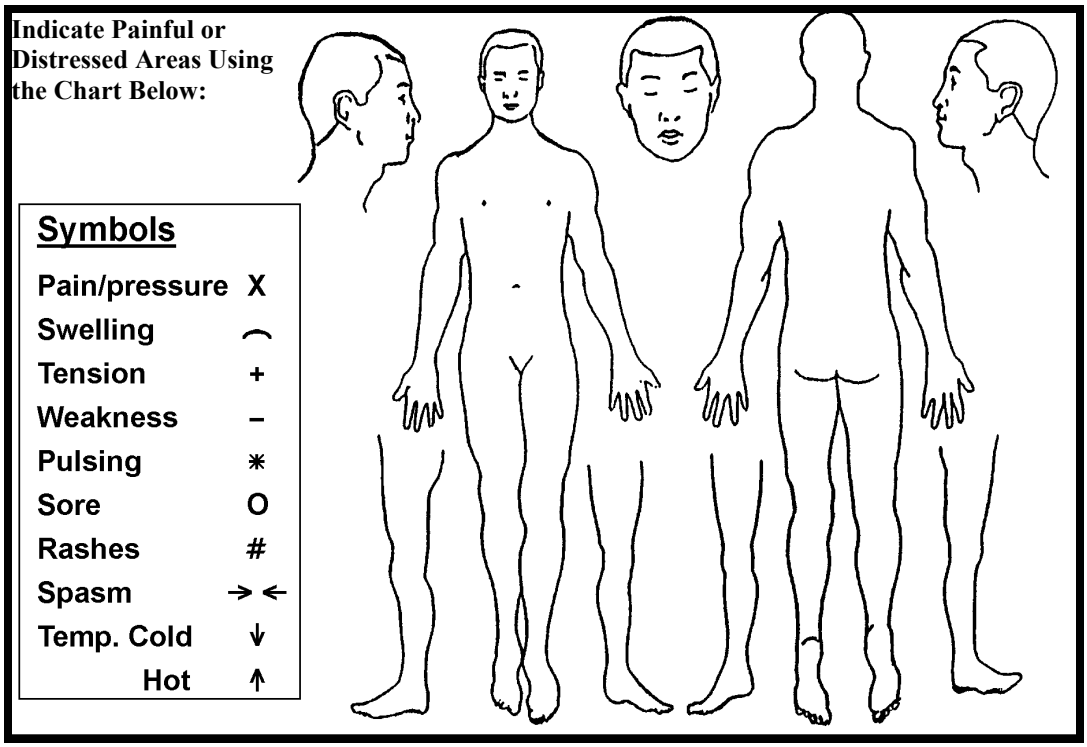
Loss of Balance Easily Susceptible to Stress Substance Abuse

Other Neurological or Psychological Problems? _____

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Indicate Painful or Distressed Areas Using the Chart Below:



Please Note the Degree of Severity of Your Problem Now:

No Problem Worst Imaginable

Please Note the Greatest Degree of Severity of Your Problem Within the Last Week:

No Problem Worst Imaginable