

To The Point Acupuncture, LLC

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CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Please take the time to fill out this questionnaire to the best of your ability. Please add details when relevant. All responses are kept confidential.

NAME: _____

DATE: _____

DOB: _____

ADDRESS (include street, apt. #, city, state, zip)

EMAIL: _____ Is it ok to email confidential information and reminders? (Y/N)

HOME PHONE: _____ WORK: _____ CELL: _____

Is it ok to leave a text message, appointment reminder, or voicemail at any of the above numbers? (Y / N)

Would you like to join our mailing list? (Y / N)

AGE: _____ HEIGHT: _____ WEIGHT _____ OCCUPATION: _____

FAMILY PHYSICIAN: _____ Phone number: _____

HEALTH INSURANCE COMPANY: _____

EMERGENCY CONTACT (name, phone number, and relation to you-please list guardian if under 18)

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

HAVE YOU EVER RECEIVED ACUPUNCTURE BEFORE? _____

MAIN PROBLEM:

What has brought you to *To The Point Acupuncture, LLC*?

Please include: To what extent this problem interferes with daily activities, how long ago this problem began, what aggravates or alleviates this condition, diagnosis (if any) given for this problem, and other treatment you have tried.

PATIENT MEDICAL HISTORY:

RECENT TESTS:

Physical Cholesterol Mammography Pap Smear
 Blood HIV/STD Prostate Other: _____

Test results and dates: _____

PAST AND PRESENT MEDICAL HISTORY: (please check all applicable)

HIV STD Tuberculosis Cancer
 Bleeding Tendency Anemia Blood disorders Heart disease
 High Blood Pressure High Cholesterol Diabetes Low blood sugar/hypoglycemic
 Glaucoma Thyroid disease Kidney stones Multiple Sclerosis
 Polio Measles Mumps Rubella Rheumatic fever
 Chicken Pox Mononucleosis Epilepsy Seizures Gout
 Hepatitis Gallbladder stones Jaundice Fatty liver/Liver disease

FAMILY MEDICAL HISTORY:

- High Blood Pressure Heart Disease High Cholesterol Stroke Cancer
- Diabetes Seizures Mental illness Allergies Other: _____

Current Medications/Herbs/Vitamins/Supplements:

(please include dosage, when began taking, how often, and reason for taking):

Allergies (drugs, chemicals, foods)

Please list any Hospitalizations/Surgeries/Significant Trauma/Major illness or disease:

Any implants, devices, or prosthetics (metal or plastic)?

LIFESTYLE:

Caffeine (intake per day): _____ **Water** (intake per day): _____

Smoking/Chew (# of packs/day): _____ **Alcohol** (# of drinks daily): _____ **Recreational Drugs** (Y / N): _____

How many hours per week do you work? _____

Do you have a regular exercise program? (type of exercise and times per week) _____

	Lowest										Highest
Stress Level:	1	2	3	4	5	6	7	8	9	10	
Energy Level:	1	2	3	4	5	6	7	8	9	10	

OVERALL TEMPERATURE:

- Cold hands/feet Raynaud’s disease Cold abdomen
- Cold body temp. (sensation) Hot body temp. (sensation) Night sweats
- Sweaty hands/feet Heat in hands, feet, chest Hot flashes (any time of day)
- Spontaneous sweating Lack of perspiration Chills

SKIN & HAIR

- Dry Oily Acne Dandruff Loss of hair
- Eczema/Psoriasis Itching Rashes Hives Ulcerations
- Lumps/cysts Warts Recent moles
- Change in hair or skin texture?
- Any other hair or skin problems: _____

HEAD, EYES, EARS, NOSE, MOUTH and THROAT:

- Glasses/Contacts Night blindness Dizziness/Vertigo Facial pain
- Blurry vision/Eye strain Color blindness Sinus problems Nose bleeds
- Tearing/Dryness Hearing loss TMJ/Jaw problems Recurrent sore throats
- Floaters/spots Ear ringing/Tinnitus Teeth grinding/clenching Sores on lips/tongue
- Cataracts Earaches/infections Teeth problems Bleeding gums
- Concussions Headaches/Migraines (location on head/frequency): _____
- Any other face or head problems: _____

CARDIOVASCULAR:

- Irregular heart beat
- High blood pressure
- Swelling of the hands/feet
- Phlebitis
- Any other heart or blood vessel problems: _____
- Chest pain/tightness
- Low blood pressure
- Blood clots
- Fainting
- Palpitations
- Varicose veins
- Murmur
- Pacemaker

RESPIRATORY:

- COPD
- Emphysema
- Bronchitis
- Pneumonia
- History of smoking (How long did you smoke for? When did you quit?) _____
- Production of phlegm- color? _____
- Persistent cough
- Asthma
- Coughing blood
- Post nasal drip
- Difficulty breathing/Shortness of breath
- Frequent colds
- Pain with a deep breath
- Allergies
- Any other lung/breathing problems: _____

DIET:

- Strong thirst
- Weight gain
- Cravings: _____
- No thirst
- Weight loss
- Water retention
- Increase/decrease in appetite
- Particular tastes/smells
- Do you follow a prescribed diet or have food restrictions/sensitivities? _____

AVERAGE DAILY DIET:

BREAKFAST:	LUNCH:	DINNER:	SNACKS:

GASTROINTESTINAL:

- Passing gas
- Ulcers
- Nausea
- Polyps
- Any other problems with your stomach or intestines: _____
- Belching
- Abdominal bloating
- Vomiting
- Diverticulitis
- Heartburn/Acid reflux/GERD
- Abdominal/Epigastric Pain
- IBS
- Colitis
- Crohn's disease

ELIMINATION/BOWELS:

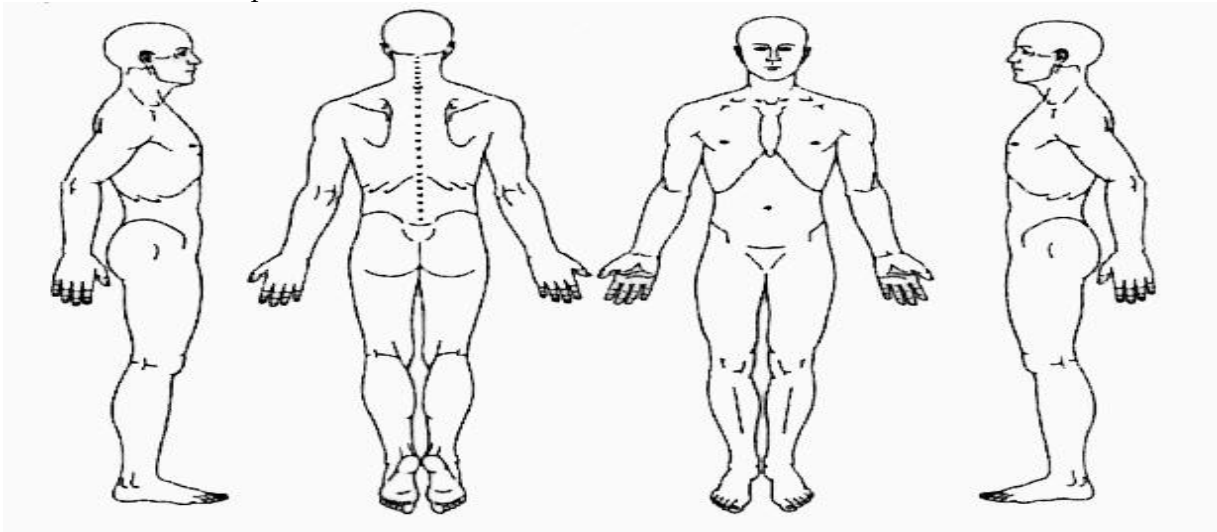
- Constipation
- Hemorrhoids
- How often do you have a bowel movement? _____
- Diarrhea
- Rectal pain
- Loose stools
- Undigested food in stools
- Black stools/blood in stool
- Chronic laxative use
- Strong odor

URINARY:

- Pain upon urination
- Urgency to urinate
- Decrease in flow
- Scanty urination
- Do you wake to urinate? How often? _____
- Any other problems with your urinary system: _____
- Frequent urination
- Unable to hold urine
- Frequent UTI or bladder infections
- Profuse urination
- Blood in urine
- Incontinence
- Cloudy urine
- Strong odor
- Color of urine: _____

Libido: High Normal Low Pain during or after intercourse

Please mark areas of pain with an X:



WHAT MAKES THE PAIN BETTER:

- Pressure Heat Cold Exercise Other: _____

WHAT MAKES THE PAIN WORSE:

- Pressure Heat Cold Exercise Other: _____
 Does weather affect the pain: Type of weather: _____
 Any other muscle, joint, or bone problems: _____

NEUROLOGICAL:

- Stroke Paralysis Numbness/Tingling
 Loss of Balance Seizures/Epilepsy Dizziness Poor Memory
 Any other neurological problems: _____

EMOTIONAL/PSYCHOLOGICAL:

- Anxiety Depression Bad Temper/irritable Panic attacks
 Over-thinker/worry Grief/sadness Fear Easily susceptible to stress
 Bipolar Manic depressive
 Have you ever been treated for any mental or emotional conditions: _____
 Have you ever attempted or considered suicide: _____
 Any other emotional issues/concerns: _____

Comments:

Please let me know of any other problems you would like to discuss
