

HEALTH HISTORY QUESTIONNAIRE

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

I. General Patient Information

Date: ___ / ___ / _____ Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

May we contact you: at home at work email: _____

Age: _____ Date of Birth: ___ / ___ / _____ Place of Birth: _____

Gender: male female Height: _____ Weight: _____ lbs.

Occupation: _____ Employer: _____

Hours worked per week _____ Is your health complaint related to work? Yes No Maybe

How did you hear about our office? _____

Guardian (if under 18): _____

Person to notify in an emergency: _____ Relationship: _____

Daytime phone for above person (_____) _____ - _____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____

2. _____ 5. _____

3. _____ Additional: _____

How do these conditions impair your daily activities? _____

II. Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays/Dates: _____

Recent tests: (please indicate test results and date below)

Physical Cholesterol Prostate Blood (which?)

HIV/STD Pap Smear Mammography Other: _____

Test Results and Date: _____

PATIENT INTAKE ORGAN FUNCTION

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a possible problem with that organ's function).

Lung Function/Large Intestine Meridian/Organ Network

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Smoke (# _ per day) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Constipation | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Loose Stools | <input type="checkbox"/> Sadness | <input type="checkbox"/> Cough | <input type="checkbox"/> Melancholy | <input type="checkbox"/> Emphysema / COPD |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Rapid, Quick Thinking | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bottle Fed as child |
| <input type="checkbox"/> Excess Phlegm | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Slow Healing Skin | <input type="checkbox"/> Mucus in Stool | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Pulmonary Diseases | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Sweating Problems | <input type="checkbox"/> Sinusitis / Rhinitis | <input type="checkbox"/> Nasal Problems | <input type="checkbox"/> Chest Congestion | _____ |
| <input type="checkbox"/> Sensitivities to: <input type="checkbox"/> Smells <input type="checkbox"/> Noise <input type="checkbox"/> Clothing <input type="checkbox"/> Energy <input type="checkbox"/> Others _____ | | | | |

Kidney/Urinary Bladder Meridian/Organ Network

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Frequent Cavities | <input type="checkbox"/> Other Dental Problems | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Easily Broken Bones | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Excessive Hair Loss | <input type="checkbox"/> Frequent Night Urination | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Easily Startled | <input type="checkbox"/> Fatigue / Lethargy | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Depression | <input type="checkbox"/> Premature Gray Hair |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Decreased Will Power | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Diseases of Spinal Column | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Sterility | <input type="checkbox"/> Cold Body Temperature |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Afternoon Flushes | <input type="checkbox"/> Hot Body Temperatures | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Heat in Chest | <input type="checkbox"/> Lack of Perspiration | <input type="checkbox"/> Perspire Easily | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Heat in Hands or feet |
| <input type="checkbox"/> Unusual Urine Out-put (Explain) _____ | | | | |

Liver/Gall Bladder Meridian/Organ Network

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Anger Easily | <input type="checkbox"/> Frustration | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pain in the Ribs |
| <input type="checkbox"/> Tightness in Chest | <input type="checkbox"/> Bitter Taste in Mouth | <input type="checkbox"/> Tingling Sensations | <input type="checkbox"/> Numbness | <input type="checkbox"/> Gall Stones History |
| <input type="checkbox"/> Gall Stones Currently | <input type="checkbox"/> Seizure | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Drink Alcohol |
| <input type="checkbox"/> Headaches on side of head | <input type="checkbox"/> PMS Symptoms | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Nausea | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Liver Spots | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Parkinsons Disease | <input type="checkbox"/> Migratory Pain |
| <input type="checkbox"/> Brittle/Coarse Nails or Hair | <input type="checkbox"/> Distention/Bloating | <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Twitching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Sensitivity to Greasy Foods | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Menstrual Cramping | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Tinnitis | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Difficulty Staying Asleep |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Belching | <input type="checkbox"/> Sour Regurgitation | <input type="checkbox"/> Churning Stomach | <input type="checkbox"/> Frequent Sighing |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Stiff Neck & Shoulders | <input type="checkbox"/> Restless Legs | | |
| <input type="checkbox"/> Repetitive Strain Disorders (Please List) _____ | | | | |

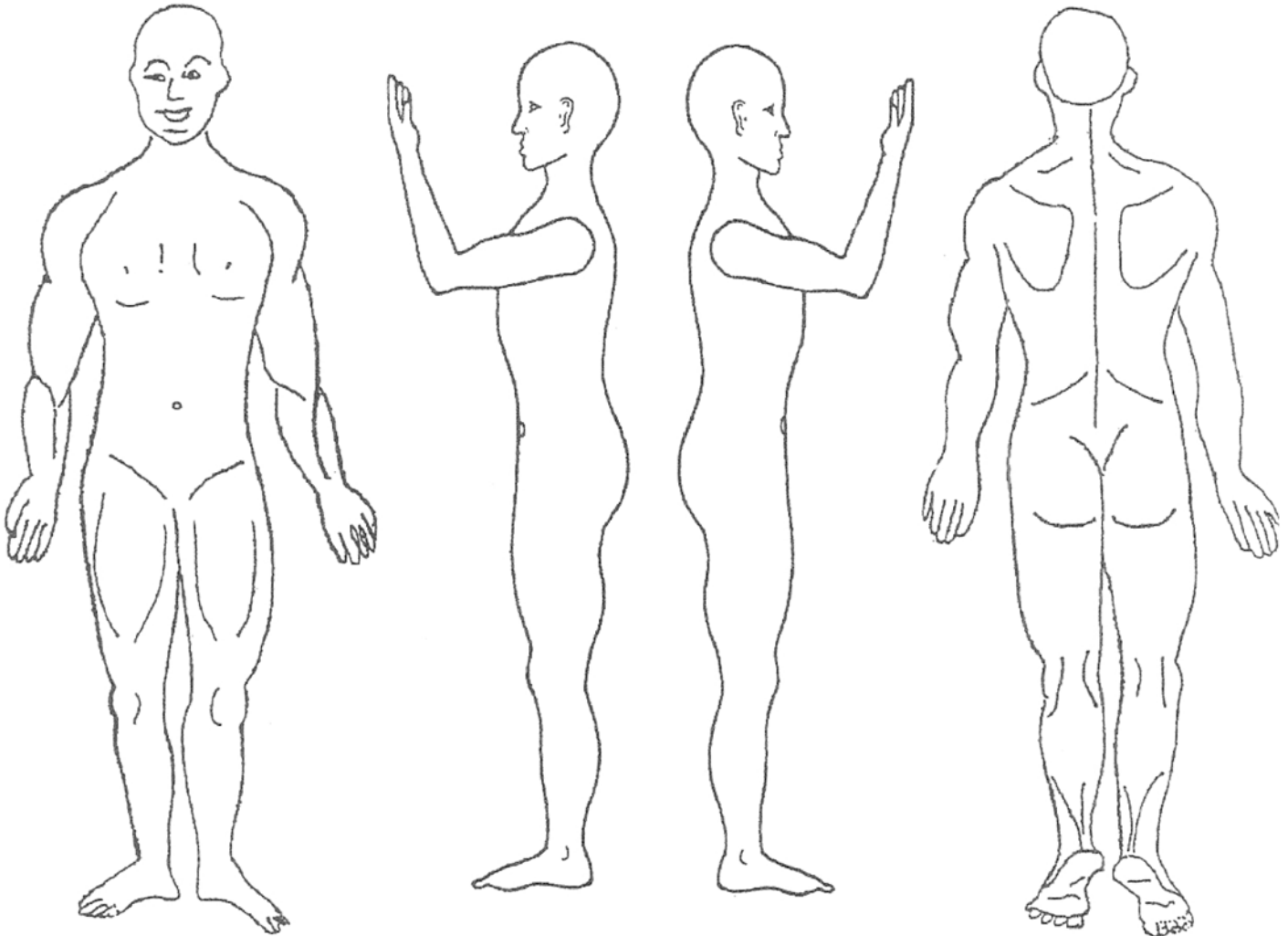
Heart/Small Intestine Meridian/Organ Network

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Mental Confusion | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chest to Shoulder Pain | <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Cold Limbs |
| <input type="checkbox"/> Sores on Tip of Tongue | <input type="checkbox"/> Wake Unrefreshed | <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Pain Down the Arm |
| <input type="checkbox"/> Drink Coffee # _ Cups/Day | <input type="checkbox"/> Dream Disturbed Sleep | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Hot Painful Joint | <input type="checkbox"/> Inflammatory Conditions | <input type="checkbox"/> Disturbed Thinking |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Tongue/Speech Problems | <input type="checkbox"/> Lack of Joy/Humor |
| <input type="checkbox"/> Cardiac Pain | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Spontaneous Sweating | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bitter Taste in Mouth | | | | |
| <input type="checkbox"/> Other (Please List) _____ | | | | |

Spleen/Stomach Meridian/Organ Network

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Low Appetite | <input type="checkbox"/> Excessive Appetite | <input type="checkbox"/> Acid Reflex | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Mouth Sores |
| <input type="checkbox"/> Abrupt Weight Gain | <input type="checkbox"/> Abrupt Weight Loss | <input type="checkbox"/> Fatigue After Eating | <input type="checkbox"/> Easily Bruised | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Over-Thinking <input type="checkbox"/> Worry | <input type="checkbox"/> Worry | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal Bloating | <input type="checkbox"/> Belching | <input type="checkbox"/> Passing Gas | <input type="checkbox"/> Hiccups |
| <input type="checkbox"/> Gurgling Noise in Stomach | <input type="checkbox"/> Ulcer (diagnosed) | <input type="checkbox"/> Burning Sensation After Eat | <input type="checkbox"/> Prolapsed Organs | <input type="checkbox"/> Aching Heavy Limbs |
| <input type="checkbox"/> Chronic Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Loose Stools | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Difficulty Focusing | <input type="checkbox"/> Non-Breast Fed | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Vein Problem | <input type="checkbox"/> Bitter Taste in Mouth |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Excess Phlegm | <input type="checkbox"/> Crohn's Disease | |

SCAR/TRAUMA CHART



Directions

All Scars: Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, etc.

All Trauma Areas: Please put a red "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such as a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury: Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

Recent tests: (please indicate test results and date below)

- Physical Cholesterol Prostate Blood (which?)
 HIV/STD Pap Smear Mammography Other: _____

Test Results and Date: _____

Check any you have had in the past:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> CVA | <input type="checkbox"/> Vein condition |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio |
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Migraines | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other lung illnesses | <input type="checkbox"/> Other kidney illnesses | <input type="checkbox"/> STDs | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other liver illnesses | <input type="checkbox"/> Other heart illnesses | <input type="checkbox"/> Other _____ | | |

Pets

Do you have pets? Yes No

If so, what kind and how many? _____

Is/are the pet allowed in the house? Yes No On your bed? Yes No

What kind of food do you feed your pets? _____

Food Choices

 Circle each type of food you eat often.

- | | | | | |
|-------------------|--------------------------------------|-------------------------------------|---|-----------------------------|
| Pre-made foods: | a) canned foods | b) boxed cereals | c) frozen dinners | d) bottled of frozen juices |
| | e) take-out food | | | |
| Red meat: | a) beef | b) pork | c) lamb commercially grown brand: naturally raised brand: | |
| Chicken: | a) commercially grown brand | b) naturally raised brand: | | |
| Turkey: | a) commercially grown brand | b) naturally raised brand: | | |
| Fish: | a) canned tuna | b) fresh fish | c) frozen fish | d) at restaurants |
| Fresh vegetables: | a) commercial (in store) | b) organic (in store) | c) organic (direct from farm) | |
| Fresh fruit: | a) commercial (in store) | b) organic (in store) | c) organic (direct from farm) | |
| Whole grains: | a) commercially grown (store bought) | b) organically grown (store bought) | c) organic (direct from farmers) | |
| Whole beans: | a) commercially grown (store bought) | b) organically grown (store bought) | c) organic (direct from farmers) | |
| Eggs/Butter: | a) commercial eggs | b) organic eggs | c) commercial butter | d) organic butter |
| Milk: | a) commercial milk | b) organic milk | c) goat's milk | |
| Cheese: | a) commercial cheese | b) organic cheese (store bought) | | |
| Other: | a) commercial ketchup | b) commercial mustard | c) vinegar | d) commercial olive oil |

Food Stressors

 On the line please indicate how many times per week you have each item.

Stimulants

coffee (including decaf.) _____
black tea, caffeine drinks _____
soft drinks (colas, etc) _____
drinks w/NutraSweet (diet soda) _____
alcohol (wine, beer, etc) _____
chocolate _____
candy, pastries, sweets _____

Toxic Oils

fried foods _____
fast food _____
potato or corn chips _____
roasted nuts _____
mayonnaise _____
margarine _____
peanut butter _____

Commercial Dairy

cow's milk _____
yogurt _____
frozen yogurt _____
ice cream _____
sour cream _____
cheese (commercial) _____
cottage cheese _____

Highly Heated Foods

bread (store bought) _____
crackers (store bought) _____
bagels (store bought) _____
buns (store bought) _____
pasta (store bought) _____
muffins (store bought) _____
cookies (store bought) _____

Food Habits

Eating Out Do you eat out at restaurants? Yes No

If yes, how often? _____ Where? _____

What type of food do you eat at restaurants? _____

Home Meals Do you prepare meals at home? Yes No

If yes, how often? _____

If yes, what type of food do you prepare? _____

Meal Habits Do you (circle) a) skip meals often b) have irregular eating times c) eat food past 7 pm

MSG Do you avoid food/drinks that list "natural flavors"
(which means hidden MSG) on the label? Yes No

Water Do you drink tap water? Yes No

What brand drinking water do you use? _____

If you have a home water purifier, when was the cartridge last changed? _____

THIS SECTION OPTIONAL

Typical Diet Please fill out your typical diet for the last few days. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked Foster Farms chicken." Instead of writing "salad," identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Olive Oil.") — PLEASE BE HONEST

Breakfast (Time eaten: _____) _____

Lunch (Time eaten: _____) _____

Dinner (Time eaten: _____) _____

Snacks (Time eaten: _____) _____

Women:

Regular menstrual cycle? Yes No

Pregnant? Yes No

Number of children: _____

Number of pregnancies: _____

Age of first menstruation: _____

Age of menopause (if applicable): _____

Average number of days of flow: _____

Average number of days of entire cycle: _____

Vaginal discharge Bleeding between periods Menstrual cramps: Mild Severe

Do you experience any of the following pre-menstrual syndromes?

- Nausea Vomiting Water retention Breast swelling
- Food cravings Headaches Migraines Breast tenderness
- Depression Irritability Anxiety Other emotions:
- Dull pain, where? Sharp pain where?

Women please fill in the following menstrual cycle.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain / Cramps (location dull, sharp, other)							
Clois (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men:

- Swollen testes Testicular pain Impotence Premature ejaculation
- Feeling of coldness or numbness in external genitalia Other _____

Medications: Please check the box if taking and *list specific medications if possible*

- Antacids Pills Blood Thinning Aspirin Birth Control Pills
- Antibiotics Cortisone Pills Vitamins Weight Reduction Pills
- Hormones Blood Pressure Iron Cough Medicine
- Pain Med. Sleeping Pills Laxatives Insulin, Diabetic
- Water Pills Tranquilizers Digitalis Thyroid Medication

Other Medications (if you have a written list give it to the receptionist to be copied) • _____

• _____ • _____ • _____

• _____ • _____ • _____

Other Comments: _____

Patient Signature: _____ Date: _____