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: _____

Phone: Home_____ Work _____ Cell _____

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: _____

_____

Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ CVA	☐ Vein condition
☐ Thyroid disorder	☐ Tuberculosis	☐ Emphysema	☐ Jaundice	☐ Bleeding Tendency
☐ Syphilis	☐ Measles	☐ Meningitis	☐ HIV	☐ Polio
☐ High Fever	☐ Hepatitis	☐ Multiple Sclerosis	☐ Migraines	☐ High Blood Pressure
☐ Other lung illnesses	☐ Other kidney illnesses	☐ STDs	☐ Rheumatic Fever	☐ Heart Disease
☐ Asthma	☐ Pneumonia	☐ Gonorrhea	☐ Mumps	☐ Chicken Pox
☐ Nervous disorder	☐ Mononucleosis	☐ Epilepsy	☐ Paralysis	☐ Cancer
☐ Other liver illnesses	☐ Other heart illnesses	☐ 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)							
Clots (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: _____

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

O Difficulty Breathing	O Smoke (# _ per day)	O Shortness of Breath	O Constipation	O Wheezing
O Loose Stools	O Sadness	O Cough	O Melancholy	O Emphysema / COPD
O Dry Skin	O Difficulty Concentrating	O Rapid, Quick Thinking	O Asthma	O Bottle Fed as child
O Excess Phlegm	O Frequent Colds/Flu	O Slow Healing Skin	O Mucus in Stool	O Other _____
O Tuberculosis	O Psoriasis	O Pulmonary Diseases	O Diarrhea	O Allergies _____
O Sweating Problems	O Sinusitis / Rhinitis	O Nasal Problems	O Chest Congestion	_____

O Sensitivities to: O Smells O Noise O Clothing O Energy O Others _____ _____

Kidney/Urinary Bladder Meridian/Organ Network

O Frequent Cavities	O Other Dental Problems	O Kidney Stones	O Easily Broken Bones	O Low Back Pain
O Memory Problems	O Excessive Hair Loss	O Frequent Night Urination	O Lack of Bladder Control	O Fear
O Easily Startled	O Fatigue / Lethargy	O Cold Hands or Feet	O Depression	O Premature Gray Hair
O Sciatica	O Decreased Will Power	O Multiple Sclerosis	O Muscular Dystrophy	O Cerebral Palsy
O Diseases of Spinal Column	O Osteoarthritis	O Infertility	O Sterility	O Cold Body Temperature
O Knee Pain	O Afternoon Flushes	O Hot Body Temperatures	O Excessive Thirst	O Night Sweats
O Heat in Chest	O Lack of Perspiration	O Perspire Easily	O Hot Flashes	O Heat in Hands or feet

O Unusual Urine Out-put (Explain) _____

Liver/Gall Bladder Meridian/Organ Network

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

O Repetitive Strain Disorders (Please List) _____

Heart/Small Intestine Meridian/Organ Network

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

O Other (Please List) _____

Spleen/Stomach Meridian/Organ Network

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

Pain Supplemental Worksheet

PAIN:

Location – Please describe_____

_____

On a scale from 1 to 10, how is the pain today? (1=best 10=worst) _____

Does the pain impair your ability to(please circle below):

work exercise sleep perform household tasks drive concentrate

What makes the pain worse?

sitting standing activity heat/cold massage stress lifting fatigue

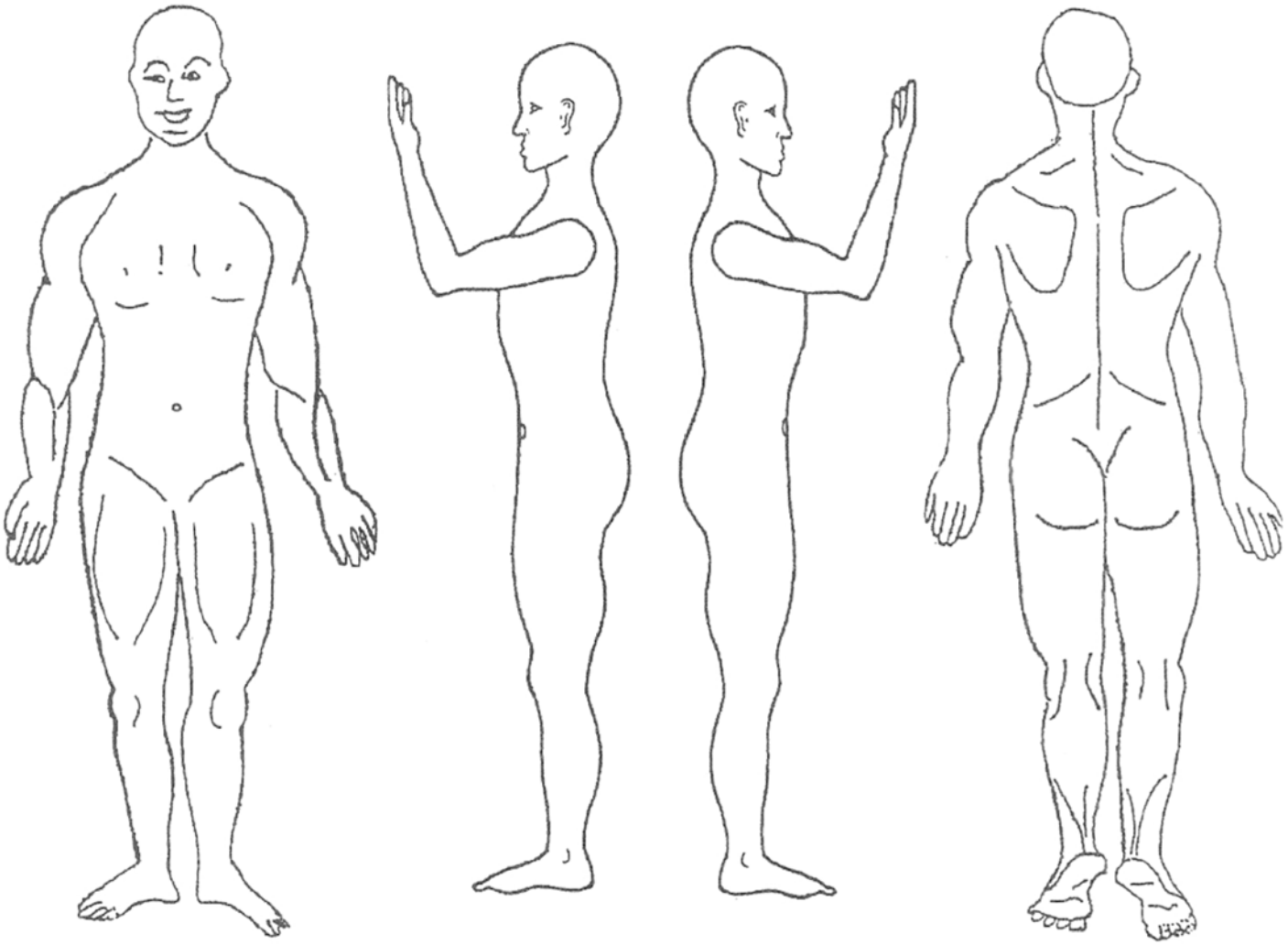
What makes the pain better?

rest activity heat/cold massage other_____

Character of Pain (circle all that apply)		Date of Initial onset_____
Dull	Distending	Cause of initial onset_____
Heavy	Superficial	What triggers the pain?_____
Sharp	Deep	_____
Ache	Throbbing	Frequency: occasional
Stabbing	Localized/Fixed	intermittent
Pulling	Changing Locations	constant

Describe pain further, in the space below, if needed.

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 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)