Accurate Acupuncture
by Remington Zhang
R.Ac., Dipl. Ac., PhD

Health History Questionnaire

Date: ___/___/___

Name:		Gender: M F	Age:
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email:	
Date of Birth:	Place of Birth:	Height:	Weight:
		Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other	
Employer:		Occupation:	
Physician:		Physician's Phone #:	
Emergency Contact Name:		Emergency Contact Phone:	
Referred By:		Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ____/____/____	

What is your main complaint today?

When did this problem begin? (Please be specific)

What do you think caused it? Is the cause still present?

What treatments have you tried already? What were the results?

Have you been given a diagnosis for this problem? If so, what?

To what extent does this problem interfere with your daily activities? (work, sleep, eating...)

How severe is your problem right now? (Please mark the scale below)

No problem — Moderate — Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem — Moderate — Worst Imaginable

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Past Medical History (please indicate by date(s):

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Allergies _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____
Other: _____			

Surgeries (type and date): _____

Significant Trauma (auto accidents, falls, etc.): _____

Significant Dental Work (type and date): _____

Birth History (prolonged labor, forceps delivery, caesarian section, other): _____

Allergies (drugs, chemicals, foods, animals): _____

Family Medical History

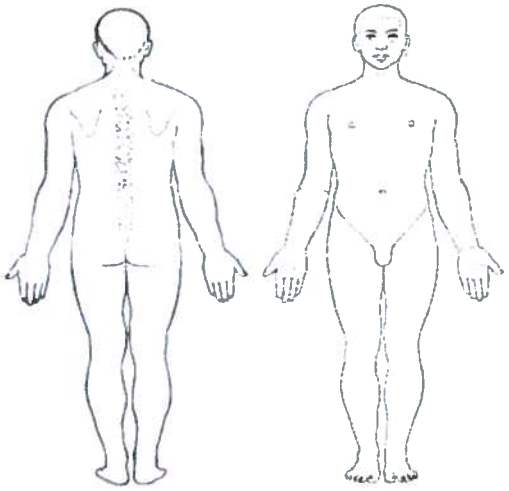
☐ High Blood Pressure	☐ Alcoholism	☐ Cancer:	☐ Allergies:
☐ Heart Disease	☐ Seizures	_____	_____
☐ Arteriosclerosis	☐ Asthma	_____	_____
☐ Stroke	☐ Diabetes	_____	_____

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you exercise regularly? Y or N Please describe: _____

Comments (please list any other problems you would like to discuss): _____

Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- ☐ Temporary relief of symptoms/pain control
- ☐ Eliminate root or cause of problem (if possible)
- ☐ Lessen/eliminate habits which caused the condition or made it worse
- ☐ Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of symptoms you have had in the past month. →

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General
- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain / Loss _____

Skin and Hair
- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

_____

Head, Eyes, Ears Nose, and Throat
- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
  *When:*_____
  Where: _____
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / neck problems

_____

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems: _____

Respiratory
- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm
  *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

_____

Gastrointestinal
- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids

*Other stomach or intestinal problems:*_____

_____

Genito-Urinary
- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?
☐ Yes ☐ No

How often? _____
What color is your urine?

_____

*Other genital or urinary system problems?*_____

_____

Pregnancy and Gynecology
of pregnancies: _____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Length of full cycle: _____
Length of menses: _____
Last menses start date:
_____/_____/_____
Last Pap smear:
_____/_____/_____
- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  Age: _____
  *Year:*_____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?
☐ Yes ☐ No

What type and for how long?

_____

Musculoskeletal
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot / ankle / heel pain
- ☐ Muscle pain
- ☐ Muscle weakness

Other pain? _____

_____

Neuropsychological
- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?
☐ Yes ☐ No

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Habits

Please indicate below: None, Light, Moderate, or Heavy. Please add comments/quantities where appropriate

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	.....
Coffee:	☐	☐	☐	☐	.....
Tea:	☐	☐	☐	☐	.....
Tobacco:	☐	☐	☐	☐	.....
Drugs:	☐	☐	☐	☐	.....
Water intake	☐	☐	☐	☐	.....
Vitamins:	☐	☐	☐	☐	.....
Sugar Intake:	☐	☐	☐	☐	.....
Food Intake:	☐	☐	☐	☐	.....
Appetite:	☐	☐	☐	☐	.....
Sleep:	☐	☐	☐	☐	.....
Exercise:	☐	☐	☐	☐	.....
Energy Level:	☐	☐	☐	☐	.....
Stress Level:	☐	☐	☐	☐	.....
Dental problems:	☐	☐	☐	☐	.....
Other:	☐	☐	☐	☐	.....

Diet

Please give a general description of the food you eat during a "typical" day.

Morning: .....

Afternoon: .....

Evening: .....

Before bed: .....

Between meals: .....

Medicine

Please list all medications you are taking, and for what condition. Please include prescriptions, vitamins, over-the-counter, etc):

Medicine	**For what condition**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Consent for treatment

I, the undersigned, understand acupuncture to involve the use of needles, electric stimulation, TDP heat therapy, cupping, gua sha, etc. The risks, although limited, include puncturing organs in the abdomen and chest cavities and bruising. Acupuncture and/or massage therapy can affect people on all levels: physical, emotional, mental and spiritual because it works with the whole body to create balance. The duration and course of treatment varies from person to person depending on their specific condition and overall constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or course of treatments.

Signature_____ Date_____