Scarsdale Health &Wellness
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HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

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: _(_____)_____

Cell Phone: _(_____)_____ Age: _____ Date of Birth: ____/____/____

Email _____

Insurance Provider: _____ Member ID: _____ Group ID: _____

Insured's Name and DOB (if other than patient): _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Medications/Supplements: _____

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:_____

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	( ) Rheumatic Fever
( ) Heart Disease	( ) CVA (stroke)	( ) Vein condition	( ) Thyroid disorder
( ) Asthma	( ) Pneumonia	( ) Tuberculosis	( ) Emphysema
( ) Jaundice	( ) Gonorrhea	( ) Mumps	( ) Bleeding tendency
( ) Syphilis	( ) Measles	( ) Chicken pox	( ) Nervous disorder
( ) Meningitis	( ) HIV	( ) Polio	( ) Mononucleosis
( ) Epilepsy	( ) High fever	( ) Hepatitis	( ) Multiple Sclerosis
( ) Paralysis	( ) Cancer	( ) Migraines	( ) High blood pressure
( ) other lung illnesses	( ) other liver illnesses	( ) other heart illnesses	( ) other kidney illnesses

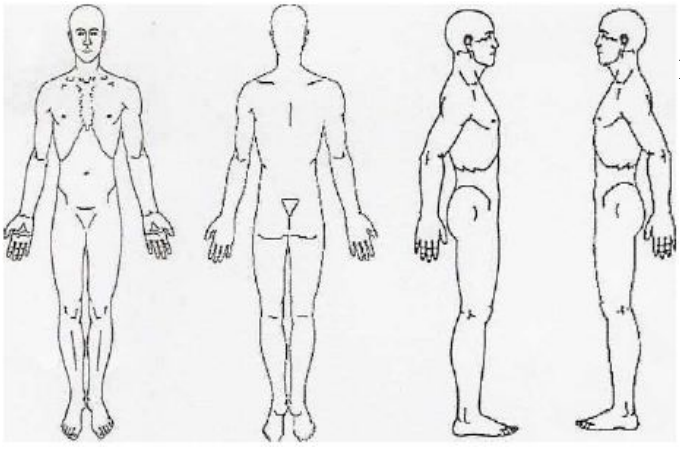
( ) other:_____

Immunizations:_____

Surgeries:_____

III. **Patient Profile**

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the pain:

( ) Sharp ( ) Burning ( ) Aching

( ) Cramping ( ) Dull ( ) Moving

( ) Fixed Other:_____

Do the following lessen the pain?

( ) Pressure ( ) Cold ( ) Heat

( ) Exercise ( ) Other:_____

Do the following worsen the pain?

( ) Pressure ( ) Cold ( ) Heat

( ) Other:_____

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

Overall Temperature (Kidney function):
- ( ) Cold hands
- ( ) Cold fingers
- ( ) Cold feet
- ( ) Cold toes
- ( ) Sweaty hands
- ( ) Sweaty feet
- ( ) Hot body temperature (sensation)
- ( ) Cold body temperature (sensation)
- ( ) Afternoon flushes
- ( ) Night sweats
- ( ) Heat in the hands, feet, and chest
- ( ) Hot flashes any time of the day
- ( ) Thirsty
- ( ) Perspire easily
- ( ) Lack of perspiration
- ( ) Take water to bed

Overall energy (Lung, Kidney function):
- ( ) Shortness of breath
- ( ) Difficulty keeping eyes open in the daytime
- ( ) General weakness
- ( ) Easily catch colds
- ( ) Low energy
- ( ) Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):
- ( ) Dizziness
- ( ) See floating black spots

Heart function:
- ( ) Palpitations
- ( ) Anxiety
- ( ) Sores on the tip of the tongue
- ( ) Restlessness
- ( ) Mental confusion
- ( ) Chest pain traveling to shoulder
- ( ) Frequent dreams
- ( ) Wake unrefreshed
- ( ) Drink coffee (# of cups per week: _____)

Lung function:
- ( ) Nasal Discharge (Color: _____)
- ( ) Cough
- ( ) Nose Bleeds
- ( ) Sinus Congestion
- ( ) Dry mouth
- ( ) Dry throat
- ( ) Dry Nose
- ( ) Dry Skin
- ( ) Allergies (To what? _____)
- ( ) Alternating fever and chills

- ( ) Sneezing
- ( ) Headache (Location: _____)
- ( ) Overall achy feeling in the body
- ( ) Stiff neck
- ( ) Stiff shoulders
- ( ) Sore throat
- ( ) Difficulty breathing
- ( ) Smoke cigarettes (# of cigarettes per day: _____)
- ( ) Sadness
- ( ) Melancholy

Spleen function:
- ( ) Low appetite
- ( ) Abrupt weight gain
- ( ) Abrupt weight loss
- ( ) Abdominal bloating
- ( ) Abdominal gas
- ( ) Gurgling noise in the stomach
- ( ) Fatigue after eating
- ( ) Prolapsed organs (previously diagnosed, which organ? _____)
- ( ) Easily bruised
- ( ) Hemorrhoids
- ( ) Pensive
- ( ) Over-thinking
- ( ) Worry

Spleen, Stomach, Large Intestine, Small Intestine function:
- ( ) Loose
- ( ) Constipated
- ( ) Incomplete
- ( ) Diarrhea
- ( ) Blood in stools
- ( ) Mucous in stools
- ( ) Undigested food in stools

Dampness trapped in the body:
- ( ) General sensation of heaviness in the body
- ( ) Mental heaviness
- ( ) Mental sluggishness
- ( ) Mental fogginess
- ( ) Swollen hands
- ( ) Swollen feet
- ( ) Swollen joints
- ( ) Chest congestion
- ( ) Nausea
- ( ) Snoring

Stomach function:
- ( ) Burning sensation after eating
- ( ) Large appetite
- ( ) Bad breath
- ( ) Mouth (canker) sores
- ( ) Bleeding, swollen or painful gums
- ( ) Heartburn
- ( ) Acid regurgitation
- ( ) Ulcer (diagnosed)
- ( ) Belching

- ( ) Hiccoughs
- ( ) Stomach pain
- ( ) Vomiting

Liver, Gall Bladder function:
- ( ) Alternating diarrhea and constipation
- ( ) Chest pain
- ( ) Tight sensation in the chest
- ( ) Bitter taste in the mouth
- ( ) Anger easily
- ( ) Frustration
- ( ) Depression
- ( ) Irritability
- ( ) Frequently unable to adapt to stress (What causes the stress? _____)
- ( ) Skin rashes
- ( ) Headache at the top of the head
- ( ) Tingling sensation
- ( ) Numbness
- ( ) Muscle spasms
- ( ) Muscle twitching
- ( ) Muscle cramping
- ( ) Seizures
- ( ) Convulsions
- ( ) Lump in the throat
- ( ) Neck tension
- ( ) Limited Range-of-Motion, Neck
- ( ) Shoulder tension
- ( ) Limited Range-of-Motion, Shoulder
- ( ) Drink alcohol
- ( ) Recreational drugs (Which? _____, How much per week? _____)
- ( ) High-pitched ringing in the ears
- ( ) Gall stones (history or current)
- ( ) Sexually transmitted disease (Which? _____)

Eyes (Liver function):
- ( ) Itchy
- ( ) Bloodshot
- ( ) Hot
- ( ) Dry
- ( ) Watery
- ( ) Gritty
- ( ) Blurry vision
- ( ) Decreased night vision
- ( ) Near-sighted
- ( ) Far-sighted

Kidney, Urinary Bladder function:
- ( ) Frequent cavities
- ( ) Easily broken bones
- ( ) Sore knees
- ( ) Weak knees
- ( ) Cold sensation in the knees
- ( ) Low back pain
- ( ) Memory problems
- ( ) Excessive hair loss
- ( ) Low-pitched ringing in the ears
- ( ) Kidney stones

( ) Bladder infections
( ) Wake during the night twice or more to urinate
( ) Lack of bladder control
( ) Fear
( ) Easily startled

Urination:
( ) Normal color
( ) Dark yellow
( ) Clear
( ) Reddish
( ) Cloudy
( ) Scanty
( ) Profuse
( ) Strong odor
( ) Burning
( ) Painful
( ) Discharge
( ) Difficult
( ) Painful
( ) Urgent
( ) Frequent

Libido:
( ) Normal
( ) High
( ) Low

Women only:

Regular menstrual cycle? ( ) Y ( ) N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
( ) Vaginal discharge

Pregnant? ( ) Y ( ) N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire cycle:_____
( ) Bleeding between periods

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?_____

Please fill in the following menstrual chart:

	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 only:

( ) Swollen testes ( ) Testicular pain ( ) Impotence ( ) Premature ejaculation
( ) Feeling of coldness or numbness in external genitalia ( ) Other_____

All please fill out:

Other Comments: _____

_____

Patient Signature: _____

Acupuncturist Signature: _____