NATURAL WONDERS HEALTHCARE
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, and Postal Code:
_____

Home Phone: (_____)_____ Age: _____

Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18):
_____

Gender: M F Height: ____' ____" Weight: _____lbs.

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?
_____

_____

HospitalVisits/Stays:_____

_____

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

- ☐ Physical
- ☐ Cholesterol
- ☐ Prostate
- ☐ Blood (type?)
- ☐ 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:

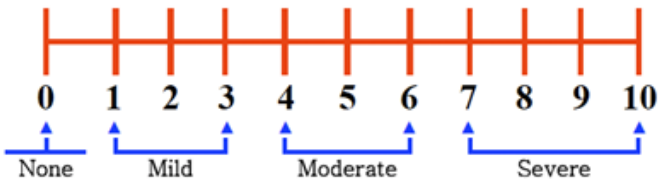
_____

_____

III. Patient Profile

On a scale of 1 to 10, 1 being no pain at all and 10 being the most excruciating pain you've ever been in please let us know what your pain level is:

_____



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
- ☐ exercise
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after

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 un-refreshed
- ☐ 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 (# 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 (if previously diagnosed, which organ(s)? _____)
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-thinking
- ☐ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

- ☐ Loose Stool
- ☐ 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
- ☐ Headache at the top of the head
- ☐ Tingling sensation
- ☐ Depression
- ☐ Irritability
- ☐ Frequently unable to adapt to stress (What causes the stress? _____)
- ☐ Skin rashes
- ☐ 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 2x 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
- ☐ Urgent
- ☐ Frequent Libido: Normal High Low

Women only:

Pregnant? Y N
Regular menstrual cycle? Y N
Date of most recent cycle_____
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? Y N
Bleeding between periods? Y N

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 (indicate if yes)							
Nausea (indicate 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: Date:

_____