# 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? _____

_____

Do you exercise or have a routine? _____

Are you happy? _____

Do you like your work? _____

Do you consider yourself healthy? _____

How long do you want to live? _____

On a scale of 0-10, how much do you believe that the body can heal itself? _____

## II. Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays/Dates: _____

_____

_____

# 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 |
| 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 | 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 Perspre 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 Staying Asleep |
| O Hiccups | O Belching | O Sour Regurgitation | O Churning Stomach | O Sighing |
| O TMJ | O Stiff Neck & Shoulders | O Restless Legs | O Compultion to Excercise | |

O Repetitive Strain Disorders (Please List) _____

## Heart / Small Intestine Meridian / Organ Network

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

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 Hemmoroids | O Excess Phlegm | O Crohn's Disease | |