

# 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

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Smoke (# _ per day)      | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Wheezing            |
| <input type="checkbox"/> Loose Stools         | <input type="checkbox"/> Sadness                  | <input type="checkbox"/> Cough                 | <input type="checkbox"/> Melancholy       | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Dry Skin             | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Rapid, Quick Thinking | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Bottle Fed as child |
| <input type="checkbox"/> Excess Phlegm        | <input type="checkbox"/> Frequent Colds/Flu       | <input type="checkbox"/> Slow Healing Skin     | <input type="checkbox"/> Mucus in Stool   | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Psoriasis                | <input type="checkbox"/> Pulmonary Diseases    | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Allergies _____     |
| <input type="checkbox"/> Sweating Problems    | <input type="checkbox"/> Sinusitis                | <input type="checkbox"/> Nasal Problems        | <input type="checkbox"/> Chest Congestion | _____  |
| <input type="checkbox"/> Sensitivities to:    | <input type="checkbox"/> Smells                   | <input type="checkbox"/> Noise                 | <input type="checkbox"/> Clothing         | <input type="checkbox"/> Energy              |
|   | <input type="checkbox"/> Others                   | _____  |   |  |

## Kidney / Urinary Bladder Meridian / Organ Network

- |  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> Frequent Cavities               | <input type="checkbox"/> Other Dental Problems | <input type="checkbox"/> Kidney Stones            | <input type="checkbox"/> Easily Broken Bones     | <input type="checkbox"/> Low Back Pain         |
| <input type="checkbox"/> Memory Problems                 | <input type="checkbox"/> Excessive Hair Loss   | <input type="checkbox"/> Frequent Night Urination | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Fear                  |
| <input type="checkbox"/> Easily Startled                 | <input type="checkbox"/> Fatigue / Lethargy    | <input type="checkbox"/> Cold Hands or Feet       | <input type="checkbox"/> Depression              | <input type="checkbox"/> Premature Gray Hair   |
| <input type="checkbox"/> Sciatica                        | <input type="checkbox"/> Decreased Will Power  | <input type="checkbox"/> Multiple Sclerosis       | <input type="checkbox"/> Muscular Dystrophy      | <input type="checkbox"/> Cerebral Palsy        |
| <input type="checkbox"/> Diseases of Spinal Column       | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> Infertility              | <input type="checkbox"/> Sterility               | <input type="checkbox"/> Cold Body Temperature |
| <input type="checkbox"/> Knee Pain                       | <input type="checkbox"/> Afternoon Flushes     | <input type="checkbox"/> Hot Body Temperatures    | <input type="checkbox"/> Excessive Thirst        | <input type="checkbox"/> Night Sweats          |
| <input type="checkbox"/> Heat in Chest                   | <input type="checkbox"/> Lack of Perspiration  | <input type="checkbox"/> Perspire Easily          | <input type="checkbox"/> Hot Flashes             | <input type="checkbox"/> Heat in Hands or feet |
| <input type="checkbox"/> Unusual Urine Out-put (Explain) | _____  |   |  |  |

## Liver / Gall Bladder Meridian / Organ Network

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> Anger Easily                              | <input type="checkbox"/> Frustration            | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Pain in the Ribs    |
| <input type="checkbox"/> Tightness in Chest                        | <input type="checkbox"/> Bitter Taste in Mouth  | <input type="checkbox"/> Tingling Sensations         | <input type="checkbox"/> Numbness               | <input type="checkbox"/> Gall Stones History |
| <input type="checkbox"/> Gall Stones Currently                     | <input type="checkbox"/> Seizure                | <input type="checkbox"/> Convulsions                 | <input type="checkbox"/> Skin Rashes            | <input type="checkbox"/> Drink Alcohol       |
| <input type="checkbox"/> Headaches on side of head                 | <input type="checkbox"/> PMS Symptoms           | <input type="checkbox"/> Fibromyaglia                | <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Tendonitis          |
| <input type="checkbox"/> Liver Spots                               | <input type="checkbox"/> Substance Abuse        | <input type="checkbox"/> Chronic Fatigue             | <input type="checkbox"/> Parkinsons Disease     | <input type="checkbox"/> Migratory Pain      |
| <input type="checkbox"/> Brittle/Coarse Nails or Hair              | <input type="checkbox"/> Distention/Bloating    | <input type="checkbox"/> Flushed Face                | <input type="checkbox"/> Muscle Spasms          | <input type="checkbox"/> Twitching           |
| <input type="checkbox"/> Cramping                                  | <input type="checkbox"/> Irritable Bowel        | <input type="checkbox"/> Sensitivity to Greasy Foods | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Menstrual Cramping                        | <input type="checkbox"/> Vertigo                | <input type="checkbox"/> Tinnitis                    | <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Staying Asleep      |
| <input type="checkbox"/> Hiccups                                   | <input type="checkbox"/> Belching               | <input type="checkbox"/> Sour Regurgitation          | <input type="checkbox"/> Churning Stomach       | <input type="checkbox"/> Sighing             |
| <input type="checkbox"/> TMJ                                       | <input type="checkbox"/> Stiff Neck & Shoulders | <input type="checkbox"/> Restless Legs               | <input type="checkbox"/> Compulsion to Exercise |  |
| <input type="checkbox"/> Repetitive Strain Disorders (Please List) | _____   |  |   |  |

## Heart / Small Intestine Meridian / Organ Network

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

## Spleen / Stomach Meridian / Organ Network

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