

Radiant Wellness & Acupuncture Center
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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: ___/___/___ Email Address: _____

Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: (____) _____ Work Phone: (____) _____

Age: _____ Date of Birth: ___/___/___ Place of Birth: _____

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

Occupation: _____ Employer: _____

Insurance Provider: _____

How did you hear about our office? _____

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)

- | | | | |
|-----------------------------------|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate | <input type="checkbox"/> Blood (which?) |
| <input type="checkbox"/> HIV/STD | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Mammography | <input type="checkbox"/> |

Other: _____

Test Results and Date: _____

Check any you have had in the past:

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> High blood pressure |

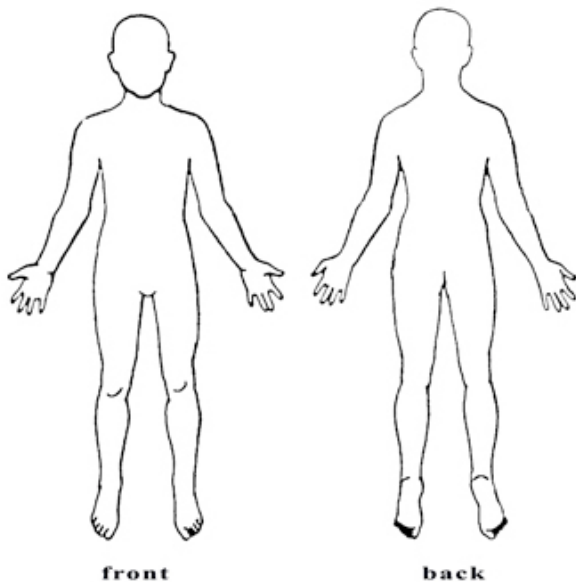
Other: _____

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:

- | | | |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ | |

Do the following lessen the pain?

- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |

Do the following worsen the pain?

- | | | |
|-----------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> 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 foginess
- 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

Do you have an aversion to wind? _____

Do you have an aversion to cold? _____

Women only:

Regular menstrual cycle? Yes No

Number of children: _____

Age of first menstruation: _____

Average number of days of flow: _____

Vaginal discharge? Y N

Pregnant? Yes No

Number of pregnancies: _____

Age of menopause (if applicable): _____

Average number of days of entire cycle: _____

Bleeding between periods? Y N

Do you experience any of the following pre-menstrual syndromes?

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> water retention | <input type="checkbox"/> breast swelling |
| <input type="checkbox"/> food cravings | <input type="checkbox"/> headaches | <input type="checkbox"/> migraines | <input type="checkbox"/> breast tenderness |
| <input type="checkbox"/> depression | <input type="checkbox"/> irritability | <input type="checkbox"/> anxiety | <input type="checkbox"/> other emotions: _____ |
| <input type="checkbox"/> dull pain, where? _____ | | <input type="checkbox"/> 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:

- | | | | |
|--|--|------------------------------------|--|
| <input type="checkbox"/> Swollen testes | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Impotence | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Feeling of coldness or numbness in external genitalia | | | <input type="checkbox"/> Other _____ |

Are you currently using any medications? Yes No If you answered yes, please tell us:

Name of medication(s): _____

Dosage (mg/timers per day): _____

Prescribed for the following conditions: _____

Please tell us about your diet. List the food you eat most often for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you crave any particular flavors? Check all that apply:

Sweet _____ Bitter _____

Salty _____

Sour _____

Please tell us:

Other Comments: _____

Patient Signature: _____

Acupuncturist Signature: _____
