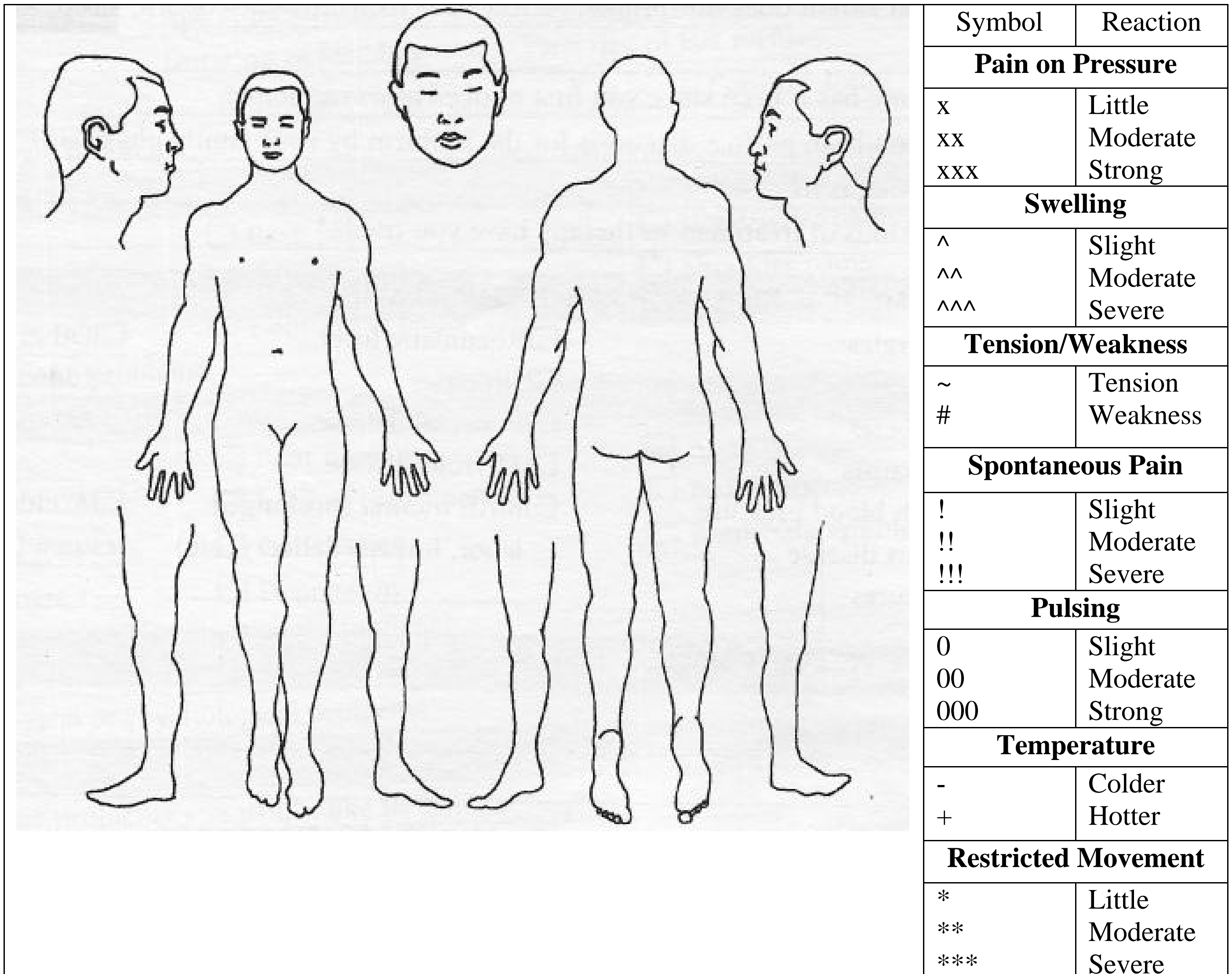
Heath History Questionnaire

Primary Health Concerns

____
____
____

When did first notice your problem?______________________________________
How long have you had this problem?______________________________________
Have you been given a diagnosis for this problem by a physician?__________________
If so what was the diagnosis and by who__________________________________
What kinds of treatments have you tried or been prescribed for you?________________
____
What makes it feel better?____
What makes it feel worse?____
Is there pain? ☐ No ☐ Yes (severe, moderate, minor)
To what extent does your complaint interfere with your daily activity?_______________

Please mark painful or distressed areas on the chart below with the symbol provided



Symbol	Reaction
Pain on Pressure	
x	Little
xx	Moderate
xxx	Strong
Swelling	
^	Slight
^^	Moderate
^^^	Severe
Tension/Weakness	
~	Tension
#	Weakness
Spontaneous Pain	
!	Slight
!!	Moderate
!!!	Severe
Pulsing	
0	Slight
00	Moderate
000	Strong
Temperature	
-	Colder
+	Hotter
Restricted Movement	
*	Little
**	Moderate
***	Severe

Other health concerns:____
____
____

Personal health goals:____
____
____

Family History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Gastrointestinal Disease
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Obesity
- ☐ Stroke
- ☐ Tuberculosis

Personal Medical History

- ☐ Alcoholism.
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Candida / Yeast Infections
- ☐ Chronic Fatigue
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gall Stones
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Kidney / Bladder Disease
- ☐ Prostate Disease
- ☐ HIV/AIDS
- ☐ Rheumatic Fever
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Urinary Infections
- ☐ Venereal Disease

Other (significant illnesses)____
Allergies (drugs, chemical, foods, etc.)____________________________________
____
____

Trauma(type, date)____
____

Dental Health:____
Surgeries (type, date)____
____
____

Prescription Medications:____
____
____

Present	Past		Present	Past		Present	Past	
☐	☐	Allergy	☐	☐	Relaxants	☐	☐	Aspirin/Tylenol
☐	☐	Antidepressants	☐	☐	Insulin	☐	☐	Decongestants
☐	☐	Antibiotics	☐	☐	Cortisone Prednisone	☐	☐	Blood Pressure
☐	☐	Chemotherapy	☐	☐	Hormones	☐	☐	Laxatives
☐	☐	Heart Medication	☐	☐	Oral Contraceptives	☐	☐	Ulcer
☐	☐	Antacids	☐	☐	Thyroid	☐	☐	Radiation

Please write Vitamins and Herbs:____
____

Lifestyle

Check if you eat, drink, or use regularly

- ☐ Alcohol
- ☐ Aspartame(nutrasweet)
- ☐ Candy
- ☐ Carbonated beverages
- ☐ Cigarettes (packs/day)______
- ☐ Coffee
- ☐ Fast food
- ☐ Fried food
- ☐ Lunch meats
- ☐ Margarine
- ☐ Nutritional supplements
- ☐ Organic foods
- ☐ Packaged foods
- ☐ Recreational drugs
- ☐ Refined flour (breads/pasta)
- ☐ Sugar
- ☐ Tobacco products

Check if you:

- ☐ Diet often
- ☐ Eat out often
- ☐ Exercise regularly
- ☐ Do not exercise regularly
- ☐ Exposed to chemicals at work or agricultural (past included)
- ☐ Exposed to chemicals in your leisure/hobby activities
- ☐ Are under high stress
- ☐ Live or work in a new structure
- ☐ Perm or dye your hair
- ☐ Live alone
- ☐ Have pets _______________
- ☐ Have a regular spiritual life

Do you follow a special diet?____

____

____

List some of your favorite foods____

____

____

Are you satisfied with your current diet?____

____

Please describe your average daily diet including times

Morning:____

____

Afternoon:____

____

Evening:____

____

Do you eat on the go or sit down to a meal? ☐ Sit ☐ Go

Do you eat when you're not hungry? ☐ Yes ☐ No

Do you snack often, what do you snack on? _______________________________________

Do you eat the same foods every day? ____

How much water do you drink daily? ____

How much coffee, tea, or soft drinks do you consume a day? _________________________

How much alcohol do you consume a day? ____

If you smoke how many years have you smoked? ___________________________________

If you have quit smoking, when did you quit and how long did you smoke? ______________

What is you main employment activity? ____

Do you enjoy your work?____

How many hours a day do you spend at job related tasks? ____________________________

Do you have children, how old? ____

What kinds of exercise do you do? ____

What leisure activities do you enjoy? ____

What kind of spiritual activities do you practice?___________________________________

Is your home: ☐ Supportive ☐ Comfortable/relaxing ☐ Stressful ☐ Lonely Check all that apply

How much sleep do you get:________ Do you have trouble sleeping, what happens?_________________

____

____

Review of Systems

Please check any conditions that you have experienced in the past six months

Skin and Hair
- ☐ Change in skin texture
- ☐ Dry
- ☐ Oily
- ☐ Itching
- ☐ Rashes/hives
- ☐ Eczema
- ☐ Flaking/dandruff
- ☐ Pimples
- ☐ Psoriasis
- ☐ Moist/clammy
- ☐ Moles
- ☐ Hair loss
- ☐ Sores/ulcers

Head, Ears, Eyes, Nose, Throat
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Jaw pain/clicking
- ☐ Teeth grinding
- ☐ Facial pain
- ☐ Tooth pain/gum bleeding
- ☐ Sores on lips or in mouth
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Blurry vision
- ☐ Eye pain/strain
- ☐ Eye lid twitching
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Color blindness
- ☐ Glasses/contacts
- ☐ Night blindness
- ☐ Constant head colds
- ☐ Nasal stuffiness
- ☐ Sinus pain
- ☐ Nose bleeds
- ☐ Swollen glands
- ☐ Recurrent sore throats

Cardiovascular
- ☐ Blood clots
- ☐ Bruise easily
- ☐ Chest pain/pressure
- ☐ Dizziness
- ☐ Cold hands and feet
- ☐ Fainting
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swelling hands or feet
- ☐ Pain or cramping in legs
- ☐ Varicose or spider veins

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Frequent Cough
- ☐ Difficulty breathing
- ☐ Excessive phlegm

What color?____________________
- ☐ Frequent chest colds
- ☐ Pain with inhalation
- ☐ Pneumonia

Gastrointestinal
- ☐ Abdominal pain or cramps
- ☐ Nausea/Vomiting
- ☐ Bad Breath
- ☐ Belching
- ☐ Black stool
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Flatulence
- ☐ Indigestion
- ☐ Loose stool
- ☐ Itching anus
- ☐ Hemorrhoids
- ☐ Pain relieved by eating
- ☐ Undigested food in stool

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Kidney stones
- ☐ Pain/burning with urination
- ☐ Waking to urinate
- ☐ Venereal disease

Men

Last prostate exam:______________
- ☐ Difficulty with sexual function
- ☐ Sores or discharge
- ☐ Incomplete bowel movement

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Knee pain
- ☐ Joint pain
- ☐ Muscle pain/soreness
- ☐ Overall stiffness
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Numbness/tingle
- ☐ Shooting pains

Neuropsychological
- ☐ Anxiety
- ☐ Depression
- ☐ Bad temper
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Poor coordination
- ☐ Frequent headache
- ☐ Easily stressed

Endocrine
- ☐ Crave sugar
- ☐ Crave salt
- ☐ Weight loss/gain
- ☐ Night sweats
- ☐ Constant fatigue
- ☐ Irritable/restless
- ☐ Sudden energy drop

Reproductive/Gynecology
- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy flow
- ☐ Light flow
- ☐ Irregular menses
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions
- ☐ Breast lumps
- ☐ Maternal history breast cancer
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Vaginal/vulvar itching
- ☐ Vaginal sores

Age at first menses_____________	Birth control ☐ Yes ☐ No
Age at menopause______________	What type____________________
Time between menses___________	How long_____________________
Duration of menses_____________	Last PAP_____________________
First day last menses____________	Results______________________
Number of pregnancies__________	

Any other gynecologic issues:____

____

Informed Consent for Acupuncture Treatment and Chinese Medicine Care

I hereby request and consent to the performance of acupuncture treatments and other Chinese Medicine procedures as outlined by Oregon state law relating to acupuncture chapter 847, division 070. I authorize the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with, or serving as a back up for the treating acupuncturist named below. Including those working at this office/clinic or any other office or clinic.

I understand that the methods of treatment include, but are not limited to acupuncture, moxabustion, electrical, thermal, mechanical, magnetic stimulation of acupuncture points; Oriental massage, exercise and related techniques; diet therapy, nutrition and herbal therapeutic agents.

I have had the opportunity to discuss with the acupuncturist named below and/or with office or clinic personnel the nature and purpose of acupuncture treatment and other procedures.

Acupuncture can act to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There may be some bruising after massage techniques or cupping.

The herbs and nutritional supplements that may be recommended are traditionally considered safe in the practice of Chinese Medicine. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise best judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand that the clinical and administrative staff may review my medical records, but all my records will be kept confidential according to HIPPA regulations and will not be released without my written consent.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____________________________________ Michael P. Pope, MS, LAc, Acupuncturist

Patient Signature or Guardian Signature

Date________________________________