

Nourishing Life Acupuncture & Chinese Herbal Medicine
Health History Questionnaire

Name:		Date:
Street Address:		
City:	State:	Zip:
Home phone:	Work phone:	Cell:
Please mark preferred contact number for reminder calls with a star		
Email:		
Date of Birth:	Place of Birth:	Age:
Employer Name:		
In emergency, please notify:		Phone:
How did you hear about our office?		
Have you been treated by acupuncture before?		Chinese herbal medicine?

Reason #1 for contacting our office: _____

Date of injury: _____ If not an injury when did the problem begin? _____

Please describe your symptoms and what makes them better or worse: _____

Has a medical diagnosis been given for this problem? _____

Previous treatments you have tried and the results: _____

Reason #2 for contacting our office: _____

Date of injury: _____ If not an injury when did the problem begin? _____

Please describe your symptoms and what makes them better or worse: _____

Has a medical diagnosis been given for this problem? _____

Previous treatments you have tried and the results: _____

Please fill download and fill out a **Functional Rating Index** for each Condition listed above.

Nourishing Life Acupuncture & Chinese Herbal Medicine
Health History Questionnaire

Last Doctor's appointment (date & reason for visit): _____

Please circle the following that apply to you:

Pregnant	Bleeding Disorder	Pacemaker	Hepatitis	Seizures
HIV	High Blood Pressure	Surgical Mesh	Chemo/Radiation	

Please describe any allergies and reactions (drugs, chemicals, foods, or environmental):

Medication/Vitamins/Supplements/Herbs:

Reason for taking it:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is your history for major
Illnesses/Traumas: _____

Surgeries: _____

Family Medical History (stroke, heart disease, high blood pressure, cancer, skin disease,
mental disorders, seizures, asthma, substance abuse, allergies, diabetes, etc.):

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Are you on a restricted diet? Yes No Please describe: _____

Nourishing Life Acupuncture & Chinese Herbal Medicine Health History Questionnaire

Please circle the appropriate number to describe the amounts consumed each day:

0 1 2 3 4 5
none ----- heavy

Wheat products (bread, pasta, pastries, etc).....	0	1	2	3	4	5
Grains & legumes.....	0	1	2	3	4	5
Dairy products (milk, cheese, butter).....	0	1	2	3	4	5
Seafood (fish & shellfish).....	0	1	2	3	4	5
Animal products (meats, poultry, eggs).....	0	1	2	3	4	5
Cooked vegetables.....	0	1	2	3	4	5
Raw vegetables.....	0	1	2	3	4	5
Water.....	0	1	2	3	4	5
Sugar.....	0	1	2	3	4	5
Salt.....	0	1	2	3	4	5
Processed foods.....	0	1	2	3	4	5

Please describe your habits by filling in the amount and frequency (daily, weekly, monthly):

Cigarettes: _____ per _____ Marijuana _____ per _____ Alcohol _____ per _____
Tea _____ per _____ Coffee _____ per _____ Soft Drinks _____ per _____

What is your work and do you enjoy it? _____

If not working, what are your main activities? _____

What do you consider your current stress level to be on a scale of 1-10? _____

What are the major stress factors in your life? _____

What do you do to relieve stress or relax? _____

How much time a day do you watch TV/movies? _____ Spend on the computer? _____

Do you have a regular exercise program? Yes No Please describe: _____

What time do you fall asleep? _____ Wake? _____ Number of hours a night? _____

How long does it take you to fall asleep? _____ Do you wake feeling rested? _____

Do you wake during the night? _____ # of times: _____ Reason: _____

Do you nap or rest during the day? _____ If so for how long? _____

Please rate your general energy level on a scale of 1-10 (one being the lowest): _____

What time of day is it the highest? _____ Lowest? _____

Emotions have physical effects on health; please rate your daily emotions on a scale of 1-5:

Anger.....	0	1	2	3	4	5
Frustration.....	0	1	2	3	4	5
Joy/Happiness.....	0	1	2	3	4	5
Worry/Anxiety.....	0	1	2	3	4	5
Sadness.....	0	1	2	3	4	5
Fear/Phobias.....	0	1	2	3	4	5
Contentment.....	0	1	2	3	4	5

Nourishing Life Acupuncture & Chinese Herbal Medicine

Health History Questionnaire

General:

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fevers | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Poor sleeping | <input type="checkbox"/> Chills | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Strong thirst (for hot or cold) | | <input type="checkbox"/> Thirst, but no desire to drink |
| <input type="checkbox"/> Cravings, for what: _____ | | <input type="checkbox"/> Change in appetite |

Skin and Hair:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Change in hair or skin | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Hives | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Recent moles | <input type="checkbox"/> Other, please specify: _____ | |

Head, eyes, ears, nose and throat:

- | | | |
|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Eyes strain |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Jaw clicks, aches |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sores on lips or inside mouth |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Spots in front of the eyes | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Headaches, where on head: _____ | | |

Cardiovascular:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Cold hands and feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Other heart or blood vessel problems: _____ | | |

Respiratory:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain on breathing | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Allergies | <input type="checkbox"/> Rhinitis |
| <input type="checkbox"/> Difficulty breathing lying down | | <input type="checkbox"/> Tight chest |
| <input type="checkbox"/> Shortness of Breath (on exertion; walking, climbing stairs, exercising, etc.) | | |
| <input type="checkbox"/> Coughing or blowing nose w/ phlegm: what color? _____ | | |
| <input type="checkbox"/> Other lung or breathing problems: _____ | | |

Gastrointestinal:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hemorrhoids | |
| <input type="checkbox"/> Other stomach or intestinal problems: _____ | | |

Nourishing Life Acupuncture & Chinese Herbal Medicine

Health History Questionnaire

Genito-Urinary:

- | | | |
|---|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Sores on genitals | |

Musculoskeletal:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/wrist pain |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Other: _____ | | |

Neuropsychological:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of concentration |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety | |

For women only:

- | | |
|---|---|
| <input type="checkbox"/> Sweet cravings | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Took birth control pills | <input type="checkbox"/> Heavy period |
| <input type="checkbox"/> Tender breasts before period | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Fluid retention | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Habitual miscarriage |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Heavy menses |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Uterine hemorrhage |
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> No period |

Age when started menses: _____ Age when started menopause: _____

Pregnancies: _____ Age: _____

Miscarriages: _____ Age: _____

Abortions: _____ Age: _____

For men only:

- | | |
|---|--|
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Exhaustion after sex |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Nighttime urination |
| <input type="checkbox"/> Scanty ejaculation | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Loss of force when urinating | <input type="checkbox"/> Dribbling after urination |

Please tell me about any other conditions that you would like to address: _____

Nourishing Life Acupuncture & Chinese Herbal Medicine
Health History Questionnaire

Privacy Policy

As mandated by Federal and State legal requirements, your health information must be protected. As part of these regulations, we are required to ensure that you are aware of our privacy practices.

Your health information may be shared between providers within Nourishing Life. Your health information will be released to another healthcare provider only if you have requested it in writing. It may be used and disclosed to obtain payment for services Nourishing Life has provided to you. We also will use your information to assist you with appointment reminders.

Informed Consent for Treatment

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including; bruising, numbness, or tingling near the needling sites that may last a few days, dizziness and fainting. Bruising is a common side effect of cupping, and burning and/or scarring are potential risks of moxibustion.

I understand that some herbs may interact with prescription drugs, over-the-counter medications, or supplements, and as such I will notify Nourishing Life if I am taking any medication or supplements concurrently with Chinese Herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify Nourishing Life if I am or become pregnant. Patients with bleeding disorders, pace makers, or surgical mesh should inform us prior to any treatment.

I do not expect Nourishing Life to be able to anticipate and explain all possible risks and complications of treatment. I understand that the results are not guaranteed. I understand that Nourishing Life is not providing Western (Allopathic) medical care, and that I should look to my Primary Care Provider (MD, ND, or DO) for those services and for routine check-ups.

I understand the acupuncture treatments are my financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. I will provide Nourishing Life with at least 24 hours notice if I need to reschedule or cancel an appointment and I understand that I will be charged a fee for any appointment cancelled or changed with less than 24 hours notice. I also understand that my insurance will not cover the fee for missed appointments.

Signature of Patient or Guardian _____ Date _____