Pamela Bellamy, L.Ac., DOM

Health History Questionnaire

Information for your Acupuncturist

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:_____ Zip:_____

E-Mail Address:_____ Home Phone: (___)_____

Work Phone: (____) _____ Cell Phone: (___) _____

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

Guardian (if under 18): _____

Gender: ❑ Male ❑ Female Height: ___ '___'' Weight:_____ lbs.

Social Security Number:_____ Driver's License Number: _____

Significant Other:_____

Occupation:_____ Employer:_____

Employer Address:_____

City: _____ State:_____ Zip:_____

Does anything limit you from care? ❑ Yes ❑ No If yes, explain:_____

_____

How did you hear about our office?_____

Other physicians / therapists seen for this condition._____

Medications (if any):_____

_____

'Treatment(s):_____

Results:_____

Supplements (if any vitamins, herbs, minerals, etc.):_____

_____

Insurance Carrier:_____

Major Complaint(s), in order of significance to you;

	Severe	Moderate	Slight	Normal	
1.	❑	❑	❑	❑	_____
2.	❑	❑	❑	❑	_____
3.	❑	❑	❑	❑	_____
4.	❑	❑	❑	❑	_____
5.	❑	❑	❑	❑	_____
6.	❑	❑	❑	❑	_____
7.	❑	❑	❑	❑	_____
8.	❑	❑	❑	❑	_____
9.	❑	❑	❑	❑	_____
10.	❑	❑	❑	❑	_____

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):

❑ Physical ❑ Cholesterol ❑ Prostate ❑ Blood (which?)

❑ HIV/STF ❑ Pap Smear ❑ Mammography ❑ Other_____

Test Results and Date:_____

_____

_____

Check any you have had in the past:

❑ Diabetes	❑ Allergies	❑ Glaucoma	❑ Rheumatic Fever
❑ Heart Disease	❑ CVA (Stroke)	❑ Vein Condition	❑ Thyroid Disorder
❑ Asthma	❑ Pneumonia	❑ Tuberculosis	❑ Emphysema
❑ Jaundice	❑ Gonorrhea	❑ Mumps	❑ Bleedingg Tendency
❑ Syphilis	❑ Measles	❑ Chicken Pox	❑ Nervous Disorder
❑ Meningitis	❑ HIV	❑ Polio	❑ Mononucleosis
❑ Epilepsy	❑ High Fever	❑ Hepatitis	❑ Multiple Sclerosis
❑ Paralysis	❑ Cancer	❑ Migraines	❑ High Blood Pressure
❑ Other Lung Illness	❑ Other Liver Illness	❑ Other Heart Illness	❑ Other Kidney Illness
❑ Other Spleen Illnesses	❑ Other Stomach Illnesses		

❑ Other:_____

Immunizations:_____

Surgeries:_____

III. Family History

Family member	Alive	Deceased	Present health or cause of death
Father	❑	❑	_____
Mother	❑	❑	_____
Spouse	❑	❑	_____
Children	❑	❑	_____
Brother	❑	❑	_____
Brother	❑	❑	_____
Brother	❑	❑	_____
Sister	❑	❑	_____
Sister	❑	❑	_____
Sister	❑	❑	_____

Where are you in the birth order? ❑ First ❑ Last ❑ Middle ❑ Only

Check the following that have occurred in your blood relatives:

❑ Diabetes	❑ Cancer	❑ Heart Disease	❑ High Blood Pressure
❑ Allergies	❑ Tuberculosis	❑ Obesity	❑ Bleeding tendency
❑ Kidney disease	❑ Alcoholism	❑ Nervous Illness	❑ Mental illness

IV. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

❑ Sharp ❑ Burning ❑ Aching

❑ Cramping ❑ Dull ❑ Moving

❑ Fixed ❑ Other_____

Do the following lessen the pain?

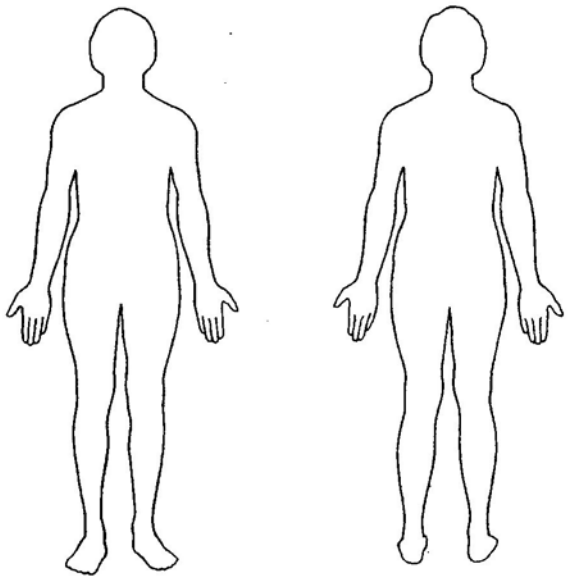
❑ Pressure ❑ Cold ❑ Heat

❑ Exercise ❑ Other: _____

Do the following worsen the pain?

❑ Pressure ❑ Cold ❑ Heat

❑ Exercise ❑ Other: _____



FRONT **BACK**

Please check the following that pertain to you:

Overall Temperature (Kidney function):

❑ Cold Hands
❑ Cold Feet
❑ 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
❑ Difficulty Keeping Eyes Open in the Daytime

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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

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 (# 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 & Chills
- ❑ Sneezing
- ❑ Headache (Location:_____)
- ❑ Overall Achy Feeling In The Body
- ❑ Stiff Neck
- ❑ Stiff Shoulders
- ❑ Sore Throat
- ❑ Difficulty Breathing
- ❑ Smoke Cigarettes (# per day:_____)
- ❑ Sadness
- ❑ Melancholy

Spleen Function:
- ❑ Low Appetite
- ❑ Abrupt Weight Gain
- ❑ Abrupt Weight Loss
- ❑ Abdominal Bloating
- ❑ Abdominal Gas
- ❑ Gurgling Noises In The Stomach
- ❑ Fatigue After Eating
- ❑ Prolapsed Organ (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 Fogginess

❑ 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
❑ Headaches at the Top Of 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 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

Other symptoms:

WOMEN ONLY:

Regular menstrual cycle? ❑ Y ❑ N Pregnant? ❑ Y ❑ N

Number of children: _____ Number of Pregnancies: _____

Age of First Menstruation:_____ Age of Menopause (if applicable):_____

Average Number of Days of Flow:_____ Average Number of Days of Entire Cycle: _____

	Severe	Moderate	Slight	Normal
Vaginal discharge:	❑	❑	❑	❑
Bleeding between periods:	❑	❑	❑	❑

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

❑ Nausea ❑ Food Cravings ❑ Depression ❑ Vomiting
❑ Headaches ❑ Irritability ❑ Water Retention ❑ Migraines
❑ Anxiety ❑ Breast Swelling ❑ Breast Tenderness
❑ Other Emotions:_____ ❑ Dull Pain, Where:? _____
❑ Sharp Pain, Where? _____
❑ Other:_____

Please fill in the following menstrual chart: (Put in a number and what color it is)

	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:

(Place X in Appropriate Column)	Severe	Moderate	Slight	Normal
Swollen Testes				
Testicular Pain				
Impotence				
Premature Ejaculation				
Feeling of coldness or numbness in external genitalia				
Other				

Other Comments: _____

_____

ALL:

Patient Signature: _____

Acupuncturist Signature: _____