The Oregon Wellness Center

Health History Questionnaire

Information for you 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.

Patient Name:_____ DOB:_____ Date:_____

Reason for visit:_____

Patient Medical History

How was your childhood health?_____

Hospital visits/stays/surgeries:_____

_____

Recent tests: (Please indicate test results and date below)

☐ Physical	☐ Cholesterol	☐ Prostate	☐ Blood
☐ HIV/STD	☐ Pap smear	☐ Mammography	☐ Other:_____

Test results and Date:_____

Immunizations:_____

Check any you have had in the past:

☐ AIDS/HIV	☐ Diabetes	☐ Measles	☐ Rheumatic Fever
☐ Alcoholism	☐ Emphysema	☐ Meningitis	☐ Scarlet Fever
☐ Allergies	☐ Epilepsy	☐ Migraines	☐ Seizures
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ STD's
☐ Arteriosclerosis	☐ Goiter	☐ Mumps	☐ Stroke
☐ Asthma	☐ Heart Disease	☐ Nervous Disorder	☐ Thyroid Disorder
☐ Birth Trauma	☐ Hepatitis	☐ Pacemaker	☐ Tuberculosis
☐ Cancer	☐ High Blood Pressure	☐ Pneumonia	☐ Ulcers
☐ Chicken Pox	☐ Jaundice	☐ Polio	☐ Vein Condition
☐ Other: _____	_____	_____	_____

Patient Name: DOB:

Patient Profile

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 function):

Temperature: (Kidney Function)

□ Cold hands	□ Cold fingers	□ Cold feet	□ Cold toes
□ Sweaty hands	□ Sweaty feet	□ Hot body temp.	□ Heat in the hands/feet
□ Afternoon flushes	□ Night sweats	□ Cold body temp.	□ Heat in the chest
□ Hot flashes	□ Thirst	□ Perspire easily	□ Lack of perspiration
□ Take water to bed			

Energy: (Lung, Spleen, Kidney Function)

□ General weakness	□ Shortness of breath	□ Difficulty keeping eyes open in daytime
□ Easily catch colds	□ Low energy	□ Feel worse after exercise

Blood: (Liver, Spleen, Heart)

□ Dizziness □ See floating black/gray spots in vision

Heart Function:

□ Palpitations	□ Anxiety	□ Sores on the tip of the tongue
□ Restlessness	□ Mental confusion	□ Chest pain traveling to shoulder
□ Frequent dreams	□ Vivid dreams	□ Wake un-refreshed

□ Drink coffee (# of cups per week:_____)

Lung Function:

□ Cough	□ Nose bleeds	□ Nasal discharge (color:_____)
□ Dry mouth	□ Dry throat	□ Sinus congestion
□ Dry nose	□ Dry skin	□ Allergies (to what:_____)
□ Sneezing	□ Headache	□ Alternating fever and chills
□ Stiff neck	□ Stiff shoulders	□ Generalized achy feeling
□ Sore throat	□ Melancholy	□ Difficulty breathing
□ Sadness	□ Smoke cigarettes (# of cigarettes per day_____)	

Spleen Function:

□ Low appetite	□ Fatigue after eating	□ Abrupt weight gain
□ Abrupt weight loss	□ Abdominal bloating	□ abdominal gas
□ Bruise easy	□ Hemorrhoids	□ gurgling noise in stomach
□ Pensive	□ Over-thinking	□ Prolapsed organs (which organ?_____)
□ Worry		

Spleen, Stomach, Large Intestine, Small Intestine Function:

□ Loose stools	□ Constipated	□ incomplete bowel movements
□ Diarrhea	□ Blood in stool	□ Mucous in stool
□ Undigested food in stool		

Patient Name: DOB:

Dampness trapped in the body:

□ Heavy Head	□Mental sluggishness	□ General sensation of heaviness/weighted down
□ Mental fogginess	□ Swollen hands	□ Swollen feet
□ Swollen joints	□ Chest congestion	□ Nausea
□ Snoring		

Stomach Function:

□ Large appetite	□ Bad breath	□ Burning sensation after eating
□		
Mouth (canker) sores	□ Heartburn	□ Bleeding, swollen or painful gums
□ Acid regurgitation	□ Ulcer	□ Belching
□ Hiccoughs	□ Stomach Pain	□ Vomiting

Liver, Gall Bladder Function:

□ Chest pain	□ Bitter taste in mouth	□ Alternating diarrhea and constipation
□ Anger easily	□ Frustration	□ Tight sensation in chest
□ Depression	□ Irritable	□ Frequently unable to adapt to stress
□ Skin rashes	□ Tingling sensations	□ Headache on top of head
□ Numbness	□ Muscle cramping	□ Muscle spasms/twitching
□ Seizures	□ Convulsions	□ Lump in throat
□ Gall stones	□ Shoulder tension	□ Shoulder-limited range of motion
□ Drink alcohol	□ Recreational drugs (which?_____Frequency_____)	
□ High pitched ringing in ears		□ STD (Which? _____)

Eyes: (Liver Function)

□ Itchy	□ Bloodshot	□ Hot	□ Dry	□ Watery
□ Gritty	□ Blurry vision	□ Near-sighted	□ Far-sighted	□ Decreased night vision

Kidney, Urinary Bladder Function:

□ Kidney stones	□ Bladder infections	□ Lack of bladder control
□ Easily broken bones	□ Frequent cavities	□ Low back pain
□ Weak knees	□ Sore Knees	□ Cold sensations in knees
□ Excessive hair loss	□ Memory problems	□ Low-pitched ringing in ears
□ Fear	□ Easily startled	□ Wake at night to urinate

Urination:

□ Normal Color	□ Dark yellow	□ Clear, no color
□ Reddish	□ Cloudy	□ Scanty
□ Profuse	□ Strong odor	□ Burning
□ Painful	□ Discharge	□ Difficult
□ Urgent	□ Frequent	

Libido: (Kidney Function)

□ Normal	□ High	□ Low

Patient Name: DOB:

Women Only:

Regular menstrual cycle? □ Yes □ No
Number of Children_____
Age of first menstruation:_____
Avg. number of days of flow:_____

Pregnant? □ Yes □No
Number of Pregnancies: _____
Age of menopause:_____
Avg. number of days of entire cycle:_____

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

□ Nausea □ Vomiting □ Water retention □ Breast swelling
□ Food cravings □ Headaches □ Migraines □ Breast tenderness
□ Depression □ Irritability □ Anxiety □ Other emotions:_____
□ Back pain □ Dull pain (where_____) □ Sharp pain (where_____)

Do you experience any of the following?

□ Vaginal Discharge □ Bleeding between periods

Men Only:

□ Swollen testes □ Testicular pain □ Impotence
□ Premature ejaculation □ Feeling of coldness or numbness in external genitalia
□ Other:_____

Please list all medications, herbs and supplements you are currently taking:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Other comments:_____
_____
_____
_____

Patient Signature:_____ Date:_____

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