Integrated Holistic Medicine Health History Questionnaire

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Name:_____ Today's Date: _____

Street:_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Work Phone:_____ E-Mail: _____

Date of Birth: ____/____/____ Age:_____ Marital Status: _____ Social Sec. No.: _____

Occupation: _____ Family Physician: _____

In Emergency, Notify: _____ Tel #: _____

Referred by: _____ Insurance Carrier: _____

Height: _____ Weight: _____lbs. Policy #: _____

Main problem(s) you would like us to help you with: _____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc)? _____

When did you first notice your symptoms? _____

Have you tried acupuncture, Chinese traditional herbal medicine or Chiropractic care before? ____Yes ____ No

Have you been given a diagnosis for the problem? If so, what and by whom? _____

_____

What kinds of treatment have you tried?_____

What response/result did you have? _____

Past Medical History (please include dates):

Significant Illnesses:

_ Cancer	_ Hepatitis	_ High Blood Pressure
_ Heart Disease	_ Seizures	_ Rheumatic Fever
_ Thyroid Disease	_ Diabetes	_ Venereal Disease

Other:_____

Surgeries: _____

Significant Emotional or Physical Trauma: _____

Birth History (prolonged labor, forceps delivery, etc.): _____

Allergies: _____

Other relevant medical history: _____

Family Medical History: (check all that apply)

_ Diabetes _ Cancer _ High Blood Pressure _ Stroke
_ Asthma _ Allergies _ Heart Disease _ Seizures

What member of your family? _____

Medicines, Vitamins, Herbs taken within the last 2 months: _____

_____

Occupation: _____ Stress Factor/Occupational Hazards: (physical, psychological,

chemical) _____

Do you follow a regular exercise program? _____ If so, please describe: _____

_____

Have you ever been on a restricted diet? ___ Yes ___ No If yes, what kind? _____

Please describe your average daily diet: _____
Morning Afternoon Evening
_____

_____

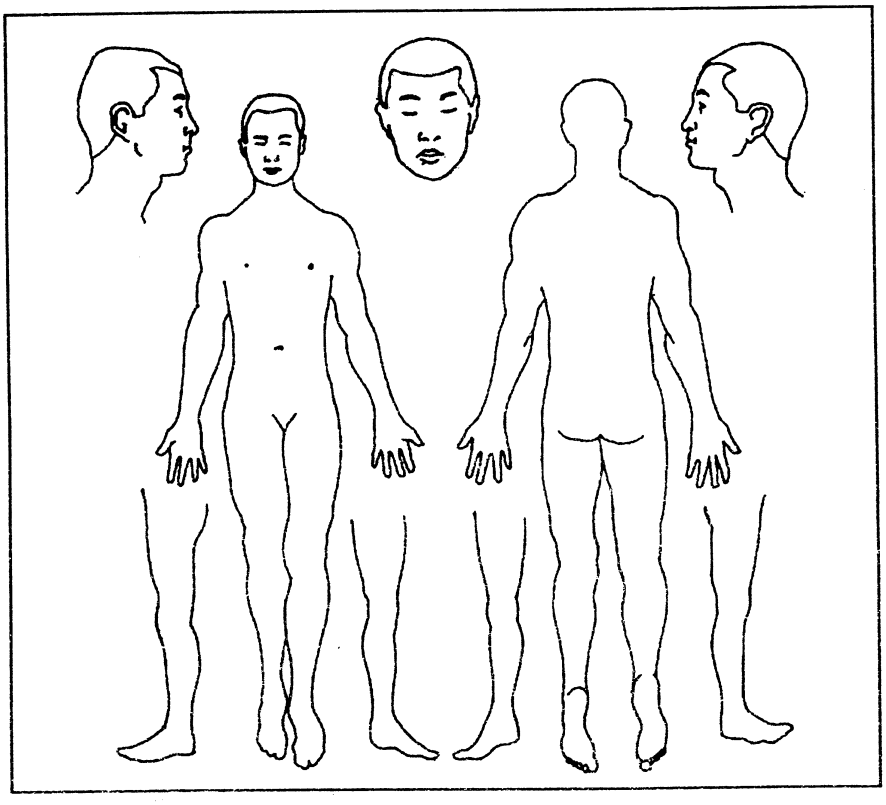
Do you smoke? _____ If so, how many cigarettes a day? _____

How much coffee, tea or cola do you drink per week? _____
How many glasses of water do you drink each day? _____

Please describe any use of drugs for non-medical purposes, current or past: _____
_____

Indicate painful or distressed areas:

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
U	weak
	normal
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
°	slight
∞	moderate
∞∞	strong
Temperature	
-	colder
	normal
+	hotter
Physical	
O	sores
‡‡	rashes
-> <-	spasms



Please check if you have had any of the following in the past 6 months:

GENERAL

_ Fatigue
_ Localized Weakness
_ Weight Loss
_ Muscle Cramps
_ Disturbed Sleep
_ Poor balance
_ Chills
_ Desire for hot/warm drinks
_ Increased Appetite
_ Sudden energy drop
_ Weight Gain
_ Cold feet
_ Heavy Sleep
_ Night Sweats
_ Peculiar Taste
_ Desire for cold drinks
_ Poor Appetite
_ Lack of Strength
_ Sweat easily
_ Cold Hands
_ Poor Sleep
_ Cravings
_ Change in Appetite
_ Bleed or bruise easily
_ Tremors
_ Bodily Heaviness
_ Poor balance
_ Fever/Feeling of heat

Any other unusual or abnormal conditions you have noticed in your general sense of health? _____

_____

MUSCULOSKELETAL

_ Neck Pain
_ Mid Back pain
_ Disc pain/problems
_ Limited Range of Motion
_ Upper back pain
_ Foot/ankle pain
_ Sciatica
_ Low Back pain
_ Hand & wrist pain
_ Fibromyalgia
_ Hand Pain/Numbness
_ Elbow pain
_ Shoulder pain
_ Muscle pain
_ Leg Pain/Numbness
_ Knee pain
_ Hip pain
_ Muscle weakness
_ Headaches/Migraine

Any other joint or bone problems? _____

GASTROINTESTINAL

_ Nausea
_ Gas
_ Constipation
_ Black Stools
_ Hemorroids
_ Vomiting
_ Bloating after meals
_ Loose Stools
_ Diarrhea
_ Abdominal pain
_ Belching
_ Acid Regurgitation
_ Blood in Stools
_ Bad Breath
_ Abdominal cramps
_ Indigestion
_ Hiccups
_ Mucous in Stools
_ Rectal Pain
_ Chronic Laxative Use

HEAD, EYES, EARS, NOSE AND THROAT

_ Dizziness/Vertigo
_ Glasses
_ Cataracts
_ Eye Pain/Strain
_ Itchy/Red Eyes
_ Sinus Problems
_ Facial Pain
_ Recurrent Sore Throat
_ Swollen glands
_ Spots/floaters
_ Poor night vision
_ Earaches
_ Gum problems
_ Teeth problems
_ Excessive saliva
_ Lumps in throat
_ TMJ
_ Blurry vision
_ Ringing in ears
_ Grinding teeth
_ Headaches*
_ Dry Mouth
_ Enlarged Thyroid
_ Migraines
_ Color blindness
_ Poor hearing
_ Sores on lips/tongue
_ Jaw clicks

Any other head or neck problems? _____

* Detail of when and where headache pain occurs: _____

GENITO-URINARY

_ Pain on urination
_ Blood in urine
_ Bedwetting
_ Sores on genitals
_ High Libido
_ Urgency to Urinate
_ Unable to hold urine
_ Decrease in flow
_ Impotency
_ Low Libido
_ Frequent Urination
_ Kidney Stones
_ Sexually Transmitted Diseases
_ Premature Ejaculation
_ Incomplete Urination

CARDIOVASCULAR

_ High Blood Pressure
_ Irregular Heart Beat
_ Swelling of Hands
_ Tachycardia
_ Dizziness
_ Swelling of Feet
_ Chest Pain
_ Fainting
_ Blood clots
_ Low Blood Pressure
_ Cold Hands/Feet
_ Shortness of Breath

RESPIRATORY

_ Cough: __wet or __dry
__thick or __thin

_ Coughing Blood
_ Post Nasal drip
_ Asthma/wheezing
_ Pneumonia
_ Allergies**
_Pain on deep breathing
_ Phlegm*
_ Tight chest
_ Difficulty breathing when lying down
_ Shortness of breath
_ Bronchitis

*What color? _____ **Allergic to what? _____

Any other lung problems? _____

SKIN, HAIR & NAILS

_ Rashes _ Psoriasis _ Bruise easily _ Hives _ Dandruff
_ Eczema _ Pimples _ Fungal infections _ Change in Skin texture _ Loss of Hair
_ Acne _ Itching _ Nail breakage _ Recent Moles _ Change in Hair texture

Any other hair, skin or nail problems? _____

REPRODUCTIVE & GYNECOLOGIC

_____Number of pregnancies _____Number of births _____Premature Births
_____Miscarriages _____Age menses began _____Number of Abortions
_____# of days in menstrual cycle _____1st date of last period _____# of days of duration of period
_____Date of last PAP test _____Age Menopause began

_ Heavy Flow _ Light flow _ Clots _ Painful periods/cramps
_ Irregular periods _ PMS _ Breast lumps _ Vaginal Sores
_ Vaginal Discharge _ Vaginal odor

Changes in body/psyche prior to menstruation: _____

Do you use birth control? _____ What method? _____

If on the birth control pill, how long have you been on that? _____

NEUROPSYCHOLOGICAL

_ Seizures _ Dizziness _ Loss of balance _ Poor Memory _ Concussion
_ Anxiety _ Easily irritated _ Bad temper _ Lack coordination _ Areas of Numbness
_ Depression _ Easily stressed _ Nervous tics _ Seeing a therapist _ Abuse survivor

Have you ever been treated for emotional problems? _____ Date(s): _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

COMMENTS

Please tell us of any other problems you would like to discuss: _____

_____

_____