



Chinese Acupuncture and Herbology Clinic

369 Montford Ave., Asheville, NC 28801 828-258-9016
206 Chadwick Ave., Hendersonville, NC 28792 828-698-3335
442 Walnut St., Waynesville, NC 28786 828-452-9699

HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Ht/Wt: _____ Age: _____

Address: _____

Email: _____ Check here to receive our email newsletter

Phone #: _____ Cell: _____

Occupation: _____ Marital status: _____

Emergency Contact Name: _____ Phone: _____

Who may we thank for referring you? _____

Recent Health Care Providers: Name, Date, Service Provided: _____

MAIN CONCERN: _____

How does this problem affect your daily activities? _____

When did you first notice symptoms? _____

If you have been diagnosed, what is diagnosis? _____

What kinds of treatment or therapies have you tried? _____

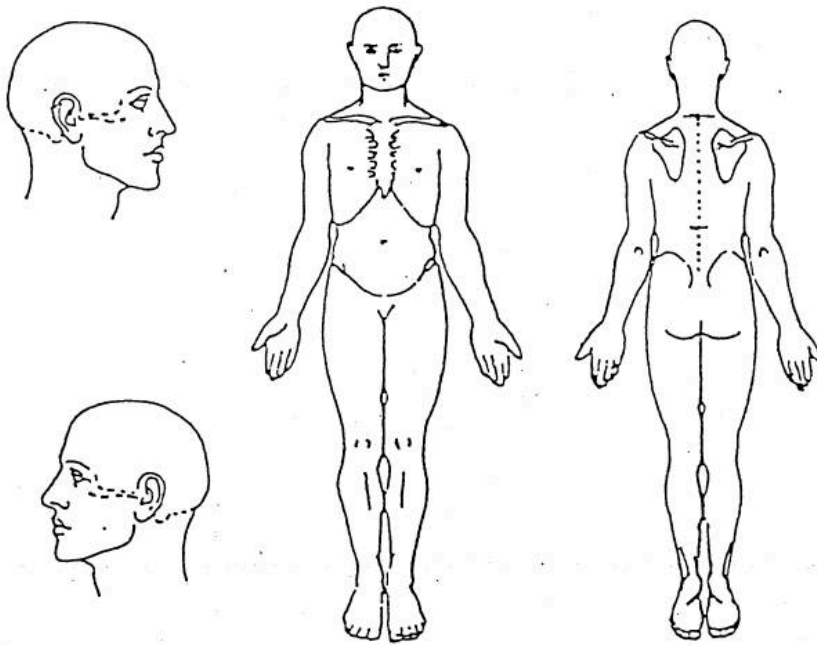
Hospitalizations/Surgeries/Accidents: _____

Allergies: _____

Family Health History

Family Member	Age	Important Diseases/Illnesses	Deceased Y/N
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Please mark painful or distressed areas on the charts below



Symbol	Reaction
Pain	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Pulsing	
O	slight
OO	moderate
OOO	strong
Weakness/Temperature	
~	weak
+	hot
Skin Problems	
*	skin issue

LIFESTYLE

Exercise

- Sedentary (No exercise)
- Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.)
- Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes)

Diet

Are you dieting? Yes No

If yes, are you on a physician prescribed medical diet? Yes No

of meals you eat in an average day? _____

Describe daily diet: _____

**Caffeine/
Alcohol/ Drugs
Tobacco**

Indicate # of cups/cans per day Coffee _____ Tea _____ Cola _____

Tobacco _____ packs per day Type? _____ # of years _____

Do you drink alcohol? Yes No

If so, how many drinks per week? _____

Do you use recreational drugs? Type _____ Yes No

MENTAL HEALTH

- Is stress a major problem for you? Yes No
- Do you feel depressed? Yes No
- Do you panic when stressed? Yes No
- Do you have problems with eating or your appetite? Yes No
- Do you cry frequently? Yes No
- Have you ever attempted suicide? Yes No
- Have you ever seriously thought about hurting yourself? Yes No
- Do you have trouble sleeping? Yes No
- Have you ever been to a counselor? Yes No

PERSONAL HISTORY

General	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Night Sweats
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fever
	<input type="checkbox"/> Disturbed Sleep	<input type="checkbox"/> Sweating easily	<input type="checkbox"/> Chills
	<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Bleeding/bruising	<input type="checkbox"/> Sudden energy drop
	<input type="checkbox"/> Cravings	<input type="checkbox"/> Tremors	<input type="checkbox"/> Poor Balance
	<input type="checkbox"/> Strong Thirst		
Skin and Hair	<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Recent moles
	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Pimples	<input type="checkbox"/> Changes in hair texture
	<input type="checkbox"/> Hives	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Hair loss
	<input type="checkbox"/> Itching		
Head, Eyes, Ears, Nose, Throat	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Recurrent sore throats
	<input type="checkbox"/> Concussions	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Nose bleeds
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Grinding teeth
	<input type="checkbox"/> Glasses	<input type="checkbox"/> Earaches	<input type="checkbox"/> Sores on lips or tongue
	<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Facial pain
	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Teeth problems
	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Eye strain	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Jaw clicks
Cardiovascular	<input type="checkbox"/> Photophobia	<input type="checkbox"/> TMJ	<input type="checkbox"/> Gum/teeth problems
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High B.P.	<input type="checkbox"/> Swelling of feet
	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Blood clots
	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Difficulty in breathing
	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Phlebitis
Respiratory	<input type="checkbox"/> Tightening in chest	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Frequent colds or flu
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Excessive phlegm
Gastrointestinal	<input type="checkbox"/> Nausea	<input type="checkbox"/> Belching	<input type="checkbox"/> Rectal pain
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Black stools	<input type="checkbox"/> Hemorrhoids
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Abdominal pain/cramps
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Chronic laxative use
	<input type="checkbox"/> Gas/ Bloating	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Chron's
	<input type="checkbox"/> Parasites	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Colitis
Genitourinary	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Sores on genitals
	<input type="checkbox"/> Low to no sex drive	<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Impotence/frigidity
	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Kidney stones	
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 pains	<input type="checkbox"/> Hip pain
	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Varicose veins	

Neuropsychological	<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Bad temper
	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Concussion	<input type="checkbox"/> Frequent mood swings
Other Illness	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Eating disorder
	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Epstein-Barr	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Underweight	<input type="checkbox"/> Overweight

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____

Period occurs every _____ days

Heavy periods, irregularity, spotting, pain, or discharge? _____

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding? _____

Have you had a D&C, hysterectomy, or Cesarean? Yes No

Any urinary tract, bladder, or kidney infections within the last year? Yes No

Any hot flashes or sweating at night? Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes No

Experienced any recent breast tenderness, lumps, or nipple discharge? Yes No

MEN ONLY

Do you usually get up to urinate during the night? Yes No

Do you feel burning discharge from penis? Yes No

Has the force of your urination decreased? Yes No

Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Please list drugs, herbs and supplements you currently take:
