HEALTH HISTORY QUESTIONNAIRE

Name:			**Date:**
Mailing Address:		**City:**	**State:**
Zip Code:		**Phone: #**	
Occupation:		**Employed by:**	
Date of Birth:	**Age:**	**Height:**	**Weight:**
Marital Status:		**Spouse's Name:**	**Number of Children:**
Spouse Employed By:			
Family Physician:			
Emergency Contact:		**Relation:**	**Phone:**
Health Insurance Carrier:			**Policy: #**
Insured Name (if other than patient):			**Insured Birth date:**
How did you hear about me?			**Have you had acupuncture before?**

Main condition you would like help with: (please describe here)

When did this condition initially begin (for the first time ever)?

What caused it then?

When did the most recent episode begin?

What brought it on this time?

Describe pain/discomfort associated with the condition.

To what extent does this condition interfere with your daily activities (work, sleep, etc.)?

What makes the condition better (heat, cold, movement, rest, food, etc.)?

What makes it worse?

Have you been given a medical diagnosis for this condition? If so, what?

What kind of treatment have you tried?

Have other treatments been successful?

Your Medical History

Significant Illnesses: diabetes hepatitis high blood pressure multiple sclerosis heart disease seizures thyroid disease rheumatic fever venereal disease

cancer (type): **other (please specify):**

Surgeries: (include date):

Significant Trauma (auto accidents, falls, broken bones, etc.):

Biomedical Devices (pacemakers, artificial joints, pins, etc.):

Significant Childhood Illnesses:

Allergies (drugs, chemicals, foods, environmental, etc,):

Family Medical History

diabetes cancer high blood pressure seizures asthma allergies
heart disease stroke alcoholism miscarriage

other (please specify):

Life Style

Do you have a regular exercise program? Please describe.

Stress factors (occupational, psychological, etc.)

Diet

Are you on a restricted diet? What kind?

Please describe you average daily diet?

Morning: ________________________ **Afternoon:** ________________________ **Evening:** ________________________

Medications

Medications taken within the last three months. Include prescriptions, vitamins, over-the-counter drugs, herbs:

Do you smoke cigarettes/cigars? Yes No If “yes” how many per day?_________________

Have you ever smoked cigarettes? When and for how long?

How much coffee, tea, or cola do you drink per day?

How much alcohol do you drink per week?

Please list any recreational drugs currently used.

Please check if you have had in the last six months:

General

- ☐ poor appetite
- ☐ fevers
- ☐ chills
- ☐ sweat easily
- ☐ night sweats
- ☐ localized weakness
- ☐ bleed or bruise easily
- ☐ peculiar tastes/smells
- ☐ edema/swelling

Where: ____________________

- ☐ strong thirst
- ☐ strong hunger
- ☐ poor sleeping
- ☐ tremors
- ☐ poor balance
- ☐ weight gain
- ☐ weight loss
- ☐ change in appetite
- ☐ sudden energy drop

Time of day: ______________

- ☐ fatigue
- ☐ desire for hot food/drink
- ☐ desire for cold food/drink

I usually feel hot/cold/moderate

Temperature preferences: ______________

Color preferences: ______________

Cravings: ______________

Favorite time of the year: ______________

Worst time of the year: ______________

Skin and Hair

- ☐ rashes
- ☐ itching
- ☐ ulcerations
- ☐ eczema
- ☐ hives
- ☐ oozing skin lesions
- ☐ dry skin
- ☐ pimples
- ☐ recent moles
- ☐ dandruff
- ☐ dry hair
- ☐ loss of hair
- ☐ premature graying
- ☐ change in hair or skin texture

Other hair/skin condition: ______________

Head, Eyes, Ears, Nose, Throat

- ☐ glasses/contacts
- ☐ poor vision
- ☐ double vision
- ☐ blind field
- ☐ cataracts
- ☐ eye strain
- ☐ eye dryness
- ☐ eye pain
- ☐ excessive tearing
- ☐ discharge from eyes
- ☐ blurry vision
- ☐ night blindness
- ☐ color blindness
- ☐ light sensitivity
- ☐ floaters
- ☐ glaucoma
- ☐ ringing ears
- ☐ poor hearing
- ☐ earaches
- ☐ ear infections
- ☐ discharge from ears
- ☐ nasal discharge
- ☐ sinus congestion
- ☐ nose bleeds
- ☐ migraines
- ☐ headaches

When: ______________

Where: ______________

- ☐ concussions
- ☐ grinding teeth
- ☐ teeth problems
- ☐ jaw clicks
- ☐ TMJ syndrome
- ☐ hoarseness
- ☐ facial pain
- ☐ facial paralysis
- ☐ sores on lips/gums/tongue
- ☐ recurrent sore throats
- ☐ frequent swollen lymph glands

Other head/face conditions: ______________

____

Cardiovascular

- ☐ high blood pressure

On medication? __________

- ☐ low blood pressure
- ☐ irregular heartbeat
- ☐ chest pain/discomfort
- ☐ palpitations
- ☐ fainting
- ☐ blood clots
- ☐ phlebitis
- ☐ varicose veins
- ☐ swelling of hands
- ☐ swelling of feet
- ☐ cold hands or feet
- ☐ hot hands or feet

Other heart/vessel conditions: ______________

Respiratory

- ☐ cough
- ☐ coughing blood
- ☐ pneumonia
- ☐ production of phlegm

What color: ______________

- ☐ asthma
- ☐ bronchitis
- ☐ wheezing
- ☐ shortness of breath
- ☐ pain with a deep breath
- ☐ difficulty breathing
- ☐ difficulty breathing when lying down

Other lung conditions: ______________

____

Please check if you have had in the last six months:

GASTROINTESTINAL

□ nausea
□ constipation
□ diarrhea
□ black stools
□ blood stools
□ abdominal pain or cramps
□ chronic laxative use
□ acid reflux

□ gas
□ vomiting
□ belching
□ bad breath
□ rectal pain
□ parasites
□ indigestion
□ heartburn

□ hemorrhoids
Bowel movements:
Frequency:______________________

URINARY

□ pain on urination
□ burning urination
□ urgency to urinate
□ frequent urination
□ unable to hold urine
□ cloudy urine

□ decrease in urine flow
□ increase in flow
□ blood in urine
□ dribbling
□ kidney stones
□ recurring urinary infections

Do you wake up to urinate?______________
How often?______________________
Urine color:______________________
Smell to urine:______________________
Other urinary conditions:______________

REPRODUCTIVE

Male:
□ impotence
□ prostate conditions

□ infertility
□ painful/swollen testicles
□ discharge from penis

□ change in sex drive
□ ejaculation irregularities
□ sores on genitals
Other:______________________

Female:
□ vaginal discharge
Color:__________________
□ vaginal/genital sores
□ endometriosis
□ painful periods
□ clots
□ irregular periods
□ ovarian cysts/fibroids
□ infertility
□ hot flashes/night sweats
□ breast tenderness
□ breast lumps: ____________
□ hysterectomy

□ change in sex drive
□ changes in body prior to menses?________________
□ emotional change prior to menses?________________

Number of pregnancies:______
Number of births:____________
Miscarriages:_______________
Abortions:_________________
Premature births:___________
Cesareans:________________
Difficult pregnancies:________
Difficult labor:_____________

Menopause age:______________________
Age at first menses:__________________
Date of start of last period:______________
Duration of flow:______________________
Time between menses:_________________
Light/Medium/heavy flow:______________
Date of last pap smear:________________
Do you use birth control:______________
Type/how long:______________________
Currently pregnant:___________________
Currently nursing:____________________
Other gynecological conditions:__________
____

MUSCULOSKELETAL AND NEUROLOGICAL

□ neck pain
□ low back pain
□ mid/upper back pain
□ hand/wrist pain
□ arm pain
□ shoulder pain
□ elbow pain
□ knee pain

□ leg pain
□ foot/ankle pain
□ hip pain
□ general muscle pain
□ muscle weakness
□ hernia
□ sciatic pain
□ areas of numbness/tingling

□ loss of balance
□ lack of coordination
□ dizziness/vertigo
□ seizures
□ concussion
□ arthritis
□ bursitis
Other muscle/nerve conditions:____________

EMOTIONS

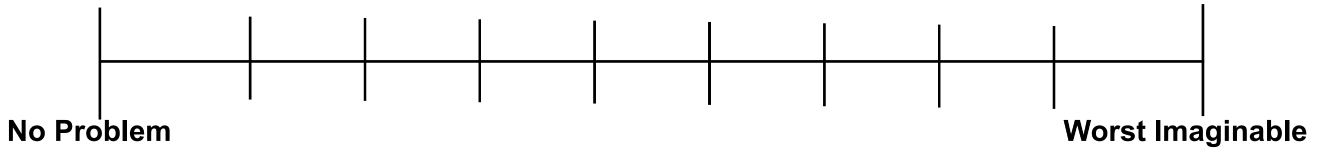
□ easily angered
□ frequent frustration
□ depression
□ anxiety
□ sadness

□ poor memory
□ worry a lot
□ overly pensive
□ grieving
□ fearful

□ ambitious/willful
□ easily susceptible to stress
Have you been treated for emotional issues?
____

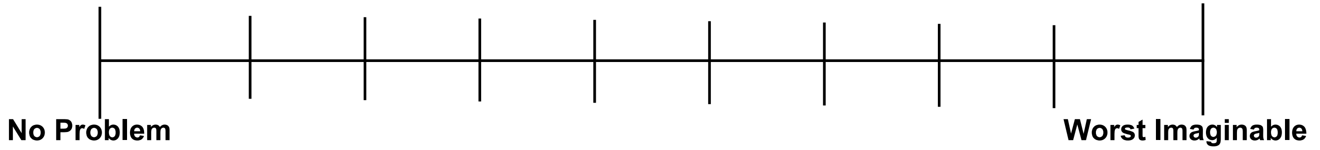
Have you ever considered or attempted suicide?______________
Other emotional issues:______________
____

Please note the severity of your problem now:
(1 being no problem 10 being the worst).



No Problem **Worst Imaginable**

Please note the greatest severity of your problem in the last week:



No Problem **Worst Imaginable**

right inner leg

left inner leg

right outer leg

left outer leg

Other conditions you would like help with:

Consent Form For Traditional Chinese Methods

I, the undersigned, hereby authorize Jennifer Gallis, licensed acupuncturist, to perform one or more of the following treatments based on her professional opinion. These treatments include, but are not limited to:

Acupuncture: Insertion of special sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.

Cupping: A technique using glass or plastic cups placed on the skin with a vacuum created by heat or suction device.

Moxa: Indirect burning on an area of the body using stick, grain, or cone moxa (an herb) to relieve symptoms.

Gua Sha: Rubbing on an area of the body with a blunt, round instrument.

Electroacupuncture: Stimulating acupuncture points by the use of electricity with or without needles.

Dietary Advice: based on traditional Chinese Medical Theory.

Shaitsu: A form of Japanese acupressure on meridians and acupoints used to treat a variety of bodily disharmonies.

Tuina: An ancient Chinese massage used to treat a wide variety of bodily disharmonies.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: discomfort, pain, infection, and blistering at the site of procedure, temporary discoloration of skin and even aggravation of symptoms existing prior to the acupuncture treatment. Patients with severe bleeding disorders or pacemakers should inform practitioners prior to treatment. Patients should also inform the practitioner if she is pregnant or has a suspected pregnancy.

Potential Benefits: drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of presenting problems.

I also authorize Jennifer Gallis to recommend Chinese herbal formulas. Herbs may be given in the form of pills, powders, tinctures, pastes, plasters, and liniments. For internal and external use. I recognize the potential risks and benefits as described below.

Potential Risks
Internal Herbs: nausea, loose stools, abdominal cramping, and possible temporary aggravation of symptoms existing prior to treatment.
External Herbs: temporary discomfort at the site of application, blistering, discoloration of skin, and even aggravation of symptoms existing prior to the treatment.

Potential Benefits: Drugless relief of presenting symptoms and improve the balance of bodily energies which may lead to prevention or elimination of the presenting problem and strengthen the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Jennifer Gallis or staff regarding cure or improvement of my condition. I hereby, release Jennifer Gallis and staff from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of patient or person legally authorized to give consent **Date**

Signature of witness **Date**