HEALTH HISTORY QUESTIONNAIRE (HHQ)

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

Name: _____ Date: _____

Street: _____

City: _____ State/Zip:_____

Cell Phone: _____ Work Phone_____

Home Phone: _____ Email: _____

Age _____ Date of Birth _____

Male _____ Female _____ Height _____ Weight _____

Race: ☐ American Indian or Alaska native ☐Asian ☐White

☐Native Hawaiian or Other Pacific Islander ☐Black or African American

Ethnicity: ☐ Hispanic or Latino ☐Not Hispanic or Latino

Marital Status: ☐Married ☐Never Married ☐Widowed ☐Divorced or Separated

Education: ☐Grammar School ☐High School ☐College ☐Masters ☐Doctorate

Occupation:_____ ☐Retired: ☐ Disabled ☐Unemployed:

Family Physician:_____ Referred by: _____

Emergency Contact:_____ Relation to you: _____

Emergency Contact telephone: _____

Have you ever been treated by acupuncture or Oriental medicine before? ☐Yes ☐No

Main Problem you would like us to help you with: _____

_____

_____

_____

How long ago did this problem begin? Please be specific:

_____

_____

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

_____

_____

What other kinds of treatment have you tried? ☐Western Medicine ☐Acupuncture

☐Herb ☐Massage ☐ Physical Therapy ☐ Chiropractor ☐Reiki ☐Homeopathy

☐Other: _____

Past Personal Medical History of Significant Illnesses: ☐Asthma ☐Allergies ☐ Diabetes

☐Cancer ☐Stroke ☐Heart Disease ☐ High Blood Pressure ☐ Seizures

☐Hepatitis ☐Rheumatic Fever ☐Thyroid disease ☐Venereal disease

Other: _____

Hospitalizations/Surgeries (including dates) & **Significant Trauma (auto accidents, falls, etc):**

_____

_____

_____

_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

_____

_____

_____

Do you have a regular exercise program? ☐No ☐Yes If yes, please describe: _____

_____

_____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?

☐No ☐Yes **If Yes, what type of diet? _____**

Describe your average daily diet:

Morning:_____

Afternoon: _____

Evening: _____

Do you smoke? ☐No ☐Yes If yes, how many cigarettes or cigars per day? _____

How many years? _____

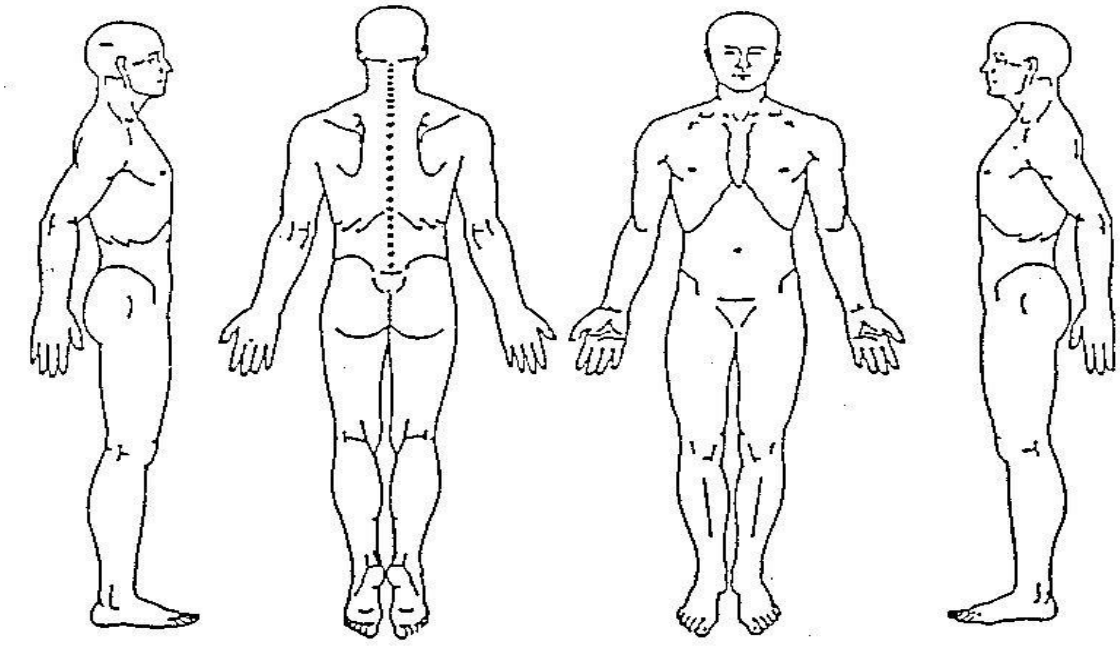
How many cups of caffeinated coffee, tea, or cola do you drink per week? _____

How many 8 oz. glasses of water do you drink per day? _____

How many alcoholic beverages do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

General:

☐Fevers ☐ Chills ☐ Fatigue ☐ Sweat easily ☐ Poor sleeping ☐ Night sweats
☐Weight loss ☐ Cravings ☐ Weight gain ☐ Change in appetite
Strong thirst for: ☐ Hot drinks ☐Cold drinks
☐Sudden energy drop, if so what time of day? _____
☐Bleed or bruise easily ☐Peculiar tastes or smells

Skin & Hair:

☐Rashes ☐Ulcerations ☐Hives ☐Itching ☐ Eczema ☐Pimples
☐ Dandruff ☐Loss of hair ☐ Recent moles ☐Psoriasis ☐Dermatitis ☐Acne
☐Change in hair or skin texture
Any other skin or hair problems? _____

Head, Eyes, Ears, Nose & Throat:

☐Dizziness ☐Concussions ☐Migraines ☐Glasses ☐Eye strain
☐Eye pain ☐ Poor vision ☐Night blindness ☐Color blindness ☐ Cataracts
☐Blurry vision ☐Earaches ☐Ringing in ears
☐Spots in front of eyes ☐Poor Hearing ☐Sinus problems
☐Nose bleeds ☐Recurrent sore throats ☐ Grinding teeth ☐Clenching jaw
☐Facial pain ☐Sore on lips or tongue ☐Teeth problems ☐Jaw clicks

Headaches, where and when? _____

Any other head or neck problems? _____

Cardiovascular:

☐High blood pressure ☐Low blood pressure ☐Chest pain ☐Fainting
☐Irregular heart beat ☐Swelling of hands ☐Swelling of feet ☐Varicose or spider veins
☐Palpitations ☐Palpitations at rest

Any other heart of blood vessel problems? _____

Respiratory:

☐Cough ☐Coughing blood ☐Asthma ☐Bronchitis ☐Pneumonia
☐Pain with deep breath ☐Chest tightness ☐Difficulty breathing when lying down

Phlegm production, quality and color? _____

Gastrointestinal:

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Gas
☐Belching ☐Black stools ☐Blood in stools ☐Indigestion
☐Bad breath ☐Rectal pain ☐Hemorrhoids ☐Bleeding gums
☐Food stagnation ☐Bloating/edema ☐Acid reflux/GRD ☐Hernia
☐Excessive appetite ☐Poor appetite ☐IBS/Crohn's disease ☐Colitis
☐Slow digestion ☐Abdominal pain/cramps ☐Chronic laxative use
☐Loose/frequent stools

☐Any other problem with stomach or intestines? _____

Genital-Urinary:

☐Frequent urination ☐Blood in urine ☐Pain upon urination ☐Urgency to urinate
☐Unable to hold urine ☐Kidney stones ☐Decrease in flow ☐Impotency
☐Sore on genitals
☐Any particular color to your urine? _____

☐Do you wake up at night to urinate? If yes, how many times a night? _____

☐Any other problems with your genital or urinary systems? _____

Reproductive & Gynecologic:

Are you pregnant? ☐Yes ☐No
Is it possible that you are pregnant? ☐Yes ☐No
Number of pregnancies: _____ Live births: _____ Miscarriages: _____
Abortions: _____ Premature births: _____
Age at first Menses: _____ Time period between menses: _____
Duration of menses: _____ Last Period date: _____
☐Irregular period ☐Painful Periods ☐Clots ☐Breast lumps
☐Vaginal sores ☐Vaginal discharge ☐Vaginal dryness ☐Endometriosis
☐Uterine fibroids ☐Polycystic Ovarian disease ☐Fibrocystic breast tissue
☐Unusual blood traits (heavy, scanty, dilute, sticky)

Do you practice birth control? ☐Yes ☐No If yes, what type? _____

How long? _____

Musculoskeletal:

☐Neck pain ☐Rotator cuff ☐Knee pain ☐Foot/ankle pain
☐Muscle pain ☐Muscle spasm ☐Muscle weakness ☐Shoulder pain
☐Hip pain ☐Sciatica ☐Bursitis ☐Hand/wrist pain
☐Carpal tunnel ☐Sprains/strains ☐Tendonitis
Back pain: Low _____ Middle _____ Upper _____
☐Soreness/weakness of lower body (back, hip, knee, ankle, foot)

Neurological & Psychological:

☐Seizures ☐Dizziness ☐Loss of balance ☐Areas of numbness
☐Poor memory ☐Concussion ☐Poor coordination ☐Bad temper
☐Anxiety ☐Depression ☐Easily susceptible to stress
☐Nervousness ☐ADD/ADHD ☐Manic depression
Have you ever been treated for emotional problems ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No

Any other neurological or psychological problems? _____

_____

_____