COLVILLE ACUPUNCTURE

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HEALTH QUESTIONNAIRE

Today's Date: ______________________________

Name: ____ Preferred Name: ________________________________

Address: ____

Email: ____ Cell #: ____

Date of Birth:____________________________________ Age: ___________

Occupation: _____________________________________ Employer: _____________________________________

Primary Doctor: __________________________________ Clinic Name: __________________________________

Gender: _________________ Pronoun: _____________ Height: _______________ Weight: _________________

Emergency contact: _______________________________ Relation: _____________ Their phone: ______________

Who can I thank for referring you? ____

Have you ever been treated with acupuncture? ____

Primary reason for visit: ____

Onset of this condition (date / event): ____

What aggravates this condition? ____

What alleviates this condition? ____

Severity of your problem now (1-10 with 10=worst imaginable): ____

In which ways does this condition interfere with your daily life (work, sleep, etc): ___________________________

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

What treatment / medications / herbs have you tried for this issue? ____

____

ROUTINES & HABITS

What is your typical **daily diet?** Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Describe any **dietary restrictions:** ____________________

Describe your **sleep** quantity and quality: ____________________

Describe your exercise: ____________________

Describe your occupational stress (physical, chemical, mental): ____________________

Describe **other stressors:** ____________________

Habits: Indicate quantity and frequency. If quit, note number of years of habit and age stopped.

Coffee / Tea: __________ Soda: __________ Alcohol: __________

Marijuana: __________ Recreational Drugs: __________

Cigarettes: __________ Other: __________

HEALTH HISTORY

Date of last doctor's visit: __________ Reason for visit: __________

Prescription & Over-The-Counter-Medications

Medication	Reason for taking

Vitamins, Herbs & Supplements

Supplement	Reason for taking

Major Hospitalizations, Surgeries, Illnesses, Traumas (physical, emotional, spiritual):

Year	Incident	Year	Incident

Allergies

Allergen	Result	Allergen	Result
________	________	________	________
________	________	________	________
________	________	________	________

For Women

1st day of last menses: ____________ Current birth control: ______________ Total # Pregnancies: ____________

Age at first menses: ______________ Past birth control: _________________ Total # births: __________________

Past Health Diagnoses

❍ Addiction	❍ Cancer	❍ Heart disease	❍ Migraines
❍ Allergies	❍ Crohn's / colitis	❍ Hepatitis	❍ Osteoporosis
❍ Alzheimers / Dementia	❍ COPD	❍ High blood pressure	❍ Stroke
❍ Arthritis	❍ Diabetes	❍ High cholesterol	❍ STD
❍ Asthma	❍ Epilepsy	❍ HIV or AIDS	❍ Autoimmune
❍ Thyroid disease	❍ Fibromyalgia	❍ Kidney infection	❍ Tuberculosis
❍ Blood disorder	❍ Heart Attack	❍ Mental Illness	❍ Other

RECENT SYMPTOMS

Please check **ALL SYMPTOMS** you have had in the last **THREE MONTHS**

Digestive:

❍ Diarrhea	❍ Rectal Pain	❍ Vomiting	❍ Cravings
❍ Constipation	❍ Bloating	❍ Peculiar tastes	❍ Acid reflux
❍ Stool changes	❍ Gas	❍ Bad breath	❍ Belching
❍ Swallowing problem	❍ Blood in stools	❍ Low appetite	❍ Other
❍ Abdominal pain	❍ Nausea	❍ Excess appetite	

Respiratory:

❍ Cough	❍ Runny nose	❍ Breathing pain	❍ Wheezing
❍ Coughing blood	❍ Blocked sinuses	❍ Breathing difficulty	❍ Other

Musculoskeletal:

❍ Neck pain	❍ Torso pain	❍ Leg pain	❍ Weakness
❍ Shoulder pain	❍ Hip pain	❍ Foot / ankle pain	❍ Stiffness
❍ Back pain	❍ Knee pain	❍ Generalized pain	❍ Other

Cardiovascular:

❍ Dizziness	❍ Chest pain	❍ Easy bleeding	❍ Swollen feet
❍ Fainting	❍ Palpitations	❍ Cold Extremities	❍ Other

Emotional:

❍ Anxiety	❍ Anger	❍ Sadness	❍ Addictions
❍ Irritability	❍ Fear	❍ Obsessions	❍ Other

Neurological:

❍ Headaches	❍ Dizziness	❍ Numbness / tingle	❍ Seizures
❍ Poor memory	❍ Fainting	❍ Loss of balance	❍ Other

Skin and Hair:

❍ Rash	❍ Dry skin	❍ Skin changes	❍ Infection
❍ Itchy skin	❍ Oily skin	❍ Hair loss	❍ Other

Eyes, Ears, Nose and Throat:

❍ Eye pain	❍ Poor hearing	❍ Jaw pain / tension	❍ Runny nose
❍ Poor vision	❍ Nose / sinus pain	❍ Tooth pain	❍ Throat pain
❍ Ear pain	❍ Nose bleeds	❍ Tooth grinding	❍ Mouth sores
❍ Ear ringing	❍ Nose congestion	❍ Gum pain/bleeding	❍ Other

Urinary:

❍ Pain on urination	❍ Night urination	❍ Dribbling	❍ Cloudy urine
❍ Urgent urination	❍ Incontinence	❍ Blood in urine	❍ Other

Men only:

❍ Erectile Dysfunction	❍ Low sperm count	❍ Discharge	❍ Genital sores
❍ Libido change	❍ Early ejaculation	❍ Genital pain	❍ Prostate
❍ Other			

Women only:

❍ Painful period	❍ Tender breasts	❍ Vaginal dryness	❍ Genital sores
❍ Irregular period	❍ Breast lumps	❍ PMS	❍ Discharge
❍ Scanty / no period	❍ Libido change	❍ Hot flashes	❍ Genital pain
❍ Heavy period	❍ Other		

Other Symptoms:

❍ Poor sleep	❍ Weight gain	❍ Sweat easily	❍ Fever
❍ Fatigue	❍ Weight loss	❍ Night sweat	❍ Chills

Comments (other issues you would like to discuss): ____

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