Brook Lewis L.Ac., EAMP

Health History Questionnaire

NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ E-MAIL _____

AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____

EMPLOYER NAME AND ADDRESS _____

FAMILY PHYSICIAN _____ REFERRED BY _____

PREFERRED PHONE _____

EMERGENCY CONTACT _____ CONTACT'S PHONE _____

Have you been treated by Acupuncture or Chinese Medicine before? ☐ Yes ☐ No

Have you been treated by Manipulation before? ☐ Yes ☐ No

What is the main complaint that brings you here?: _____

How long have you noticed these symptoms? _____

To what extent do the symptoms affect your daily well- being? _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried? _____

Please note the severity of your problem now:

NO PROBLEM — WORST IMAGINABLE

Please note the severity of your problem withing the last week:

NO PROBLEM — WORST IMAGINABLE

Past medical history: (please include dates)

☐ Cancer _____	☐ Heart Disease _____	☐ Venereal Disease _____
☐ Diabetes _____	☐ Rheumatic Fever _____	☐ HIV/AIDS _____
☐ Hepatitis _____	☐ Thyroid Disease _____	☐ Other _____
☐ High Blood Pressure _____	☐ Seizures _____	_____

Surgeries (type and date) _____

Significant Trauma (auto accidents, falls, etc.) _____

_____

Significant Dental Work (type and date) _____

_____

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

Allergies (drugs, chemicals, food/results) _____

Family Medical History ○ Diabetes ○ Cancer ○ High Blood Pressure ○ Heart Disease

○ Stroke ○ Seizures ○ Asthma ○ Allergies ○ Other _____

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

_____

Occupational Stress (physical, chemical psychological, etc.) _____

_____

Do you have a regular exercise program? ○ Yes ○ No Please describe: _____

_____

Are you on a restricted diet? ○ Yes ○ No What kind? _____

_____

Please describe your average daily diet?

Morning: _____

Afternoon: _____

Evening: _____

How many cigarettes do you smoke per day? _____ How many cups coffee, tea, or cola do you drink per day? _____ How much alcohol do you drink a week? _____

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

Please check any you have had in the last three months:

General

☐ Poor appetite
☐ Fevers
☐ Sweat easily
☐ Localized weakness
☐ Peculiar tastes or smells
☐ Strong thirst (cold or hot?)
☐ Thirsts, no desire to drink
☐ Sudden energy drop
☐ Poor sleep
☐ Chills
☐ Tremors
☐ Poor balance
☐ Fatigue
☐ Night sweats
☐ Cravings
☐ Change in appetite
☐ Weight gain
☐ Weight loss

Skin and Hair

☐ Rashes
☐ Itching
☐ Dandruff
☐ Change in hair or skin
☐ Ulcerations
☐ Eczema
☐ Loss of hair
☐ Hives
☐ Acne
☐ Recent moles
☐ Other _____

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Head, Eyes, Ears, Nose, and Throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throat
- ☐ Sores on lips or tongue
- ☐ Headaches when:
- ☐ Other

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing
- ☐ Other _____

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficult breathing
- ☐ Production of phlegm
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with deep breath
- ☐ Other _____

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other _____

Genitourinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Other _____
- Do you wake up to urinate?
- ○ Yes ○ No
- How often? _____
- Any particular color to your urine? _____

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Other _____

Neuro-psychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Other _____

Pregnancy and Gynecology

- ☐ Number of pregnancies _____
- ☐ Number of births _____
- ☐ Premature births _____
- ☐ Miscarriages _____
- ☐ Abortions _____
- ☐ Age of first menses _____
- ☐ Days between menses _____
- ☐ Duration _____
- ☐ Unusual character (heavy or light)
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal sores
- ☐ Irregular periods
- ☐ Last Pap _____
- ☐ Breast lumps
- ☐ Do you practice regular birth control?
- ○ Yes ○ No
- ☐ What type and for how long?
- ☐ Other _____

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