

HEALTH HISTORY QUESTIONNAIRE

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Healing Spring Acupuncture

Acupuncture - Allergy Elimination - Emotional Release - Herbal Prescriptions

(520) 400 - 4625

Name: _____
Street: _____ City _____ State _____ Zip _____
Email: _____
Home Phone: _____ Work Phone: _____
Date of Birth: _____ Social Security Number: _____
Occupation: _____
In Emergency Notify: _____
Referred by: _____
Family Physician: _____
Have you tried acupuncture or Chinese herbal medicine before? _____

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for the problem by your family physician? _____

If so, what is it? _____

What kinds of treatment have you tried? _____

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES):

- | | |
|---|---|
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Surgeries _____ | <input type="checkbox"/> Venereal Disease _____ |
| <input type="checkbox"/> Thyroid Disease: _____ | |
| <input type="checkbox"/> Other significant illness (describe): _____ | |
| <input type="checkbox"/> Accidents or Significant Trauma (describe) _____ | |

OTHER RELEVANT MEDICAL HISTORY: _____

FAMILY MEDICAL HISTORY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Other _____ |

OCCUPATION: _____

Occupational stress factors (physical, psychological, chemical): _____

LIFESTYLE:

Do you follow a regular exercise program? _____ If so, please describe: _____

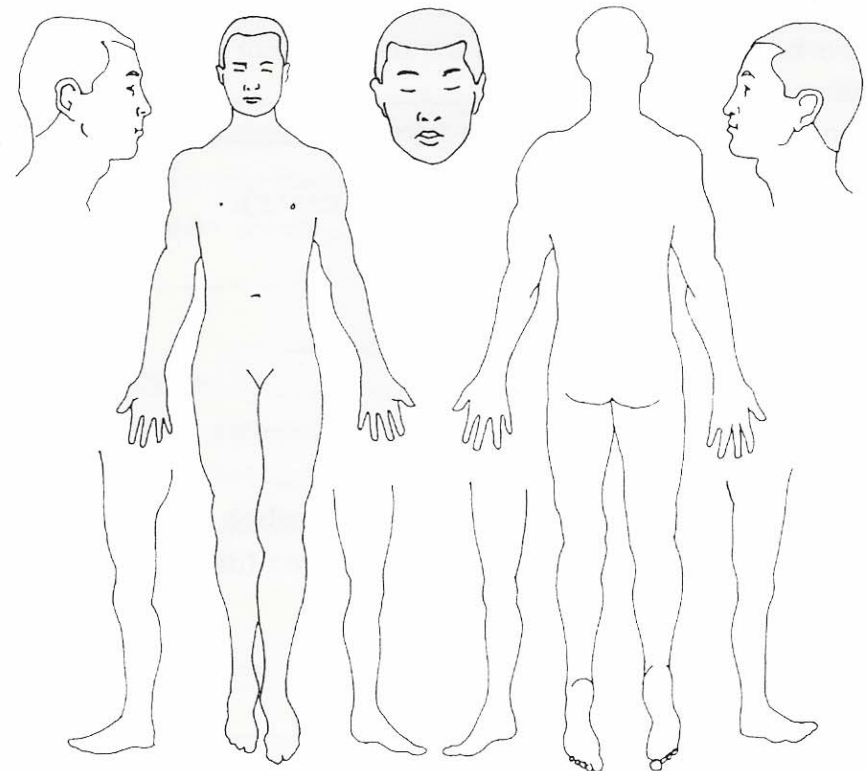
Please describe your average daily diet: _____

Please check any of the following habits that apply. Indicate how much and how often you consume them: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Cigarette smoking _____ | <input type="checkbox"/> Coffee, tea or cola _____ | <input type="checkbox"/> Alcoholic beverages _____ |
|--|--|--|

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

INDICATE PAINFUL OR DISTRESSED AREAS



PLEASE PUT A CHECK NEXT TO CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION:

GENERAL:

- Poor appetite _____
- Localized weakness _____
- Weight gain _____
- Sweating easily _____
- Night Sweats _____
- Sudden energy drop (time of day?) _____
- Other unusual or abnormal conditions you have noticed in your general sense of health? _____
- Insomnia _____
- Cravings _____
- Weight loss _____
- Tremors _____
- Fever _____
- Poor balance _____
- Disturbed sleep _____
- Strong thirst _____
- Changes in appetite _____
- Bleeding or bruising easily _____
- Chills _____

SKIN AND HAIR

- Rashes _____
- Itching _____
- Dandruff _____
- Changes in hair or skin texture _____
- Ulcerations _____
- Eczema _____
- Hair loss _____
- Hives _____
- Pimples _____
- Recent moles _____

Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT

- Dizziness _____
- Glasses _____
- Poor vision _____
- Cataracts _____
- Ringing in ears _____
- Sinus problems _____
- Grinding teeth _____
- Teeth problems _____
- Concussions _____
- Spots in front of eyes _____
- Night blindness _____
- Blurry vision _____
- Poor hearing _____
- Recurrent sore throats _____
- Sores on lips or tongue _____
- Headaches (where? when?) _____
- Migraines _____
- Eye pain _____
- Color blindness _____
- Earaches _____
- Eyestrain _____
- Nose bleeds _____
- Facial pain _____
- Jaw clicks _____

Any other head or neck problems? _____

CARDIOVASCULAR

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

Any other heart or blood vessel problems? _____

RESPIRATORY

- Cough _____
- Bronchitis _____
- Difficulty breathing when lying down _____
- Coughing up blood _____
- Pain with deep inhalation _____
- Production of phlegm (color?) _____
- Asthma _____
- Pneumonia _____

Any other lung problems? _____

GASTROINTESTINAL

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

Any other problems with stomach or intestines? _____

GENITO-URINARY

- Pain on urination _____
- Frequent urination _____
- Blood in urine _____
- Urgency to urinate _____
- Unable to hold urine _____
- Kidney stones _____
- Decrease in flow _____
- Impotence _____
- Sores on genitals _____

Do you wake up at night to urinate? _____ If so, how often? _____

Any particular color to your urine? _____

Any other problems with your genital or urinary functions? _____

REPRODUCTIVE AND GYNECOLOGIC

- Menstrual clots _____
- Painful menses _____
- Unusual menses _____
- Changes in body/psyche prior to menstruation _____ (heavy or light?) _____
- Irregular menses _____
- Menopause (age? _____)
- Other problems _____

Age at first menses _____ Length of time between menses _____ Duration _____

First day of last menses _____ Number of pregnancies _____ Premature births _____

Miscarriages _____ Abortions _____ Number of births _____

Do you practice birth control? _____ If so, what type? _____ For how long? _____

MUSCULOSKELETAL

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

Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL

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

Any other neurological or psychological problems? _____

COMMENTS

Please tell us of any other problems you would like to discuss: _____
