

Pathways Acupuncture



Health History Questionnaire

Pathways Acupuncture ♦ 621 2nd St ♦ Encinitas, CA 92024 ♦ 760.688.8814

Important: The information on this form will help your doctor to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

All of the information provided is strictly confidential

General Patient Information

Today's Date ___ / ___ / ___

Name: _____ Age: _____ D.O.B. ___ / ___ / ___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

E-Mail Address _____ Occupation: _____ Employer: _____

Gender: Male Female || **Height:** _____' _____" || **Current weight:** _____ lbs. || **Ideal weight:** _____ lbs

Highest level of education: Elementary High School Associate's College Master's PhD.

Marital Status: Single Married Separated Divorced Widowed

Spouse's Name _____

Spouse's Occupation: _____ Spouse's Place of Employment: _____

Name of guardian (if under 18) _____

In case of emergency, whom should we notify? _____ Relationship: _____

Contact Number: _____ Address: _____

How did you hear about our office? _____

Name of your primary health care provider: _____

What are your hobbies / things that you most enjoy doing? _____

Major Health Complaint(s). Please list in order of significance to you, along with how long you've had each one:

| Major Health Complaints / Symptoms | How Long? | Additional Health Complaints / Symptoms | How Long? |
|------------------------------------|-----------|---|-----------|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

Do you know what is causing this problem(s)? _____

Do these problems affect your Work Relationships Hobbies Sports / Play General quality of life

Please explain how these conditions affect or impair your daily activities

Describe your symptoms when they are at their worst: _____

List any other conditions or complaints that you would like us to know about: _____

If you do not take steps to improve your health and / or symptoms now, do you think your condition will get worse? Yes No

If your condition continues on its current course, what do you think your symptoms will be like 5 years from now?

What do you think is most preventing you from being healthy? _____

What are 5 things that you know you could do to improve your health? (1) _____

(2) _____ (3) _____

(4) _____ (5) _____

On a scale of 1-10, how committed are you to becoming healthy? (circle one) 1 2 3 4 5 6 7 8 9 10

Patient Medical History

Please describe your childhood health _____

Have you ever been hospitalized? If so, please describe the procedures you had done, and the dates.

Recent Medical Tests or Procedures (please indicate test results and dates below)

Physical Cholesterol Prostate exam Blood test
 HIV / STD Pap smear Mammogram Other

Test Results and Date: _____

Check any conditions that you have had in the past, or are currently experiencing:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding or hemorrhage |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Auto Immune Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Other _____ | | | |

List any surgeries that you've had (Include the year of the surgery): _____

Patient Health Profile

Please check any of the following symptoms that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function)

Overall Body Temperature (Kidney Organ System)

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body temperature | <input type="checkbox"/> Profuse perspiration | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Afternoon flushing | <input type="checkbox"/> Night sweating | |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Strong thirst | |

Overall Energy (Lung and Kidney System)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Easily prone to illness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sweating without exertion | <input type="checkbox"/> Frequent colds / flus / sinuses | <input type="checkbox"/> Chronic allergies |

Blood Function (Liver, Heart and Spleen System)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in extremities | <input type="checkbox"/> Itchy or dry | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fainting | <input type="checkbox"/> Weak or brittle nails |

Heart Function

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Manic moods | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Tongue ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Speech impediment |
| <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Severe shyness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rapid Heart Beating | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral valve prolapse |

Lung Function

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Dry or flaky skin | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Nasal dryness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Cigarette smoking |
- Allergies to Mold Cedar Pet fur Dust Pollen Oak Hay Fever Environmentally Sensitive

If you are a smoker, # of cigarettes per day _____ How long have you been smoking? _____

If you are a smoker, do you want to quit? Yes No [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Spleen Function

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Gurgling in intestines | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Gas | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Strong food cravings | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Indigestion |

Stomach Function

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Mouth ulcers |

Bowel Function and Elimination (Intestinal Function)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty moving bowels | <input type="checkbox"/> I.B.S. or Colitis |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Small, hard, dry stools | <input type="checkbox"/> Chron's Disease |
| <input type="checkbox"/> Incomplete stools | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Less than 1 BM/ Day | <input type="checkbox"/> Eating Disorder |

Accumulated Dampness

- | | | |
|---|---|---|
| <input type="checkbox"/> Mental foginess | <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Edema in the legs |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Swollen feet | <input type="checkbox"/> Edema in the abdomen |
| <input type="checkbox"/> Poor mental focus | <input type="checkbox"/> Joint stiffness / ache | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Heaviness of the head, the limbs, or of the whole body | <input type="checkbox"/> Symptoms worsen in rainy weather | |

Liver and Gall Bladder Function

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Pain in the ribcage | <input type="checkbox"/> Acne |
| <input type="checkbox"/> All over body tension | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Heaviness in ribcage | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Chronic neck tension | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Numbness / tingling | <input type="checkbox"/> Shoulder tension | <input type="checkbox"/> Gall stones |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Eye pain / dryness |
| <input type="checkbox"/> Alternating diarrhea and constipation <input type="checkbox"/> Easily overwhelmed by stressful circumstances | | | |

Please list any non-prescription or recreational drugs you currently take _____

Eyes (Liver Function)

- | | | | |
|--------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Far sighted |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Seeing spots | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Red and irritated | <input type="checkbox"/> Near sighted | <input type="checkbox"/> Glaucoma |

Kidney and Urinary Bladder Function

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Weak knees | <input type="checkbox"/> Cold lower back | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Broken / loose teeth | <input type="checkbox"/> Knee soreness | <input type="checkbox"/> Cold hips / buttocks | <input type="checkbox"/> Early graying of hair |
| <input type="checkbox"/> Weak bones | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cold knees | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Quick to fear / fright |

Urinary Function

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Reddish color | <input type="checkbox"/> Small amount | <input type="checkbox"/> Night-time urination |
| <input type="checkbox"/> Dark Yellow | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Large amount | <input type="checkbox"/> UTI / Pain or burning |
| <input type="checkbox"/> Clear color | <input type="checkbox"/> Strong odor | <input type="checkbox"/> Very frequent | <input type="checkbox"/> Hesitancy |
| <input type="checkbox"/> Difficulty initiating the stream of urination | | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Weak stream |

Libido Function

- Normal High sex drive Diminished sex drive Vaginal dryness
 Early ejaculation Spermatorrhea Nocturnal emissions Infertility
 Difficulty getting or maintaining an erection Fatigue following sexual activity
 Thick or dense semen Discolored or yellow semen Pain in the penis or testicles

Women only:

- Regular menstrual cycle? Y N Pregnant? Y N
 Number of children: _____ Number of pregnancies: _____
 Age of first menstruation: _____ Age of menopause (if applicable): _____
 Average number of days of flow: _____ Average number of days of entire cycle: _____
 Vaginal discharge Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

- Nausea Vomiting Water retention Breast swelling
 Food cravings Headaches Migraines Breast tenderness
 Depression Irritability Anxiety Other emotions: _____
 Dull pain, where? _____ Sharp pain, where? _____

Please fill in the following menstrual chart:

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|--|-------|-------|-------|-------|-------|-------|-------|
| Color (normal, bright red, pale, brown, rust, dark, purple, other) | | | | | | | |
| Amount of flow (normal, heavy, light) | | | | | | | |
| Pain/cramps (location, dull, sharp, other) | | | | | | | |
| Clots (large, small, black, purple, red, other) | | | | | | | |
| Vomiting (check if yes) | | | | | | | |
| Nausea (check if yes) | | | | | | | |
| Other | | | | | | | |

Men only:

- Swollen testes Testicular pain Impotence Premature ejaculation
 Feeling of coldness or numbness in external genitalia Other _____

All please fill out:

Other Comments:

Patient Signature: _____

Date:

Acupuncturist Signature: _____

Date: