

HEALTH HISTORY QUESTIONNAIRE

Welcome to the Jade and Cinnabar Oriental Medicine Center. Please take the time to fill out the questionnaire as carefully and thoroughly to facilitate a complete evaluation. Though some of the questions that follow may seem unrelated to your complaint, they play a major role in diagnosis and treatment of your condition.

All information is strictly confidential.

Date: ____ / ____ / ____

Name: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Place of Birth _____

Gender: Male / Female _____ Height: _____ Weight: _____

Guardian if under 18: _____

Social Security Number: _____ - _____ - _____

Occupation: _____ Marital Status: _____

E-mail: _____ 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 a physician or chiropractor? _____

If so, what is it? _____

What kinds of treatment or therapy have you tried? _____

Is the condition getting better? _____

PAST MEDICAL HISTORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Birth trauma
(prolonged labor, forceps
delivery, etc.) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Accidents or significant
trauma (describe) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Other significant illness
(describe) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Measles | |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chicken pox | |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Mononucleosis | |
| | <input type="checkbox"/> Surgeries | |

Other relevant medical history: _____

FAMILY MEDICAL HISTORY

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Alcoholism | |

LIFESTYLE

Rate your general satisfaction with life: 1 being very low, 10 being excellent _____

Do you enjoy your job? _____ Do you often feel overworked? _____

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

When was your last vacation? _____ What do you do for recreation? _____

Do you follow any religious or spiritual practice? _____ Please specify: _____

Do you meditate or use relaxation exercises? _____

What do you enjoy most in your life? _____

What areas of your life do you find stressful? _____

Financial Job-related Interpersonal Marriage Children Family Health Expectations Other _____

Rate your overall stress levels: 1 being very low, 10 being very high _____

Who lives with you? _____

Do you engage in physical activity / follow a regular exercise program? _____

If so, please describe: _____

Never Occasionally Several times a month Once a week Several times a week Daily

Please describe your average daily diet: Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Please check any of the following habits that apply:

Cigarette smoking Coffee, tea or soda Alcoholic beverages

How much and how often do you use them?

___ x day / week

___ x day / week

___ x day / week

List medications taken within the last six months (vitamins, drugs, herbs, etc.):

Medication:

What are you taking it for?

Dose/amount:

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

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

GENERAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Not refreshed in the morning | <input type="checkbox"/> Sweating easily |
| <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Feeling moody in the mornings | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Feel angry /irritable/ depressed / frustrated / stressed out | <input type="checkbox"/> Unusual sweating (palms, soles, or chest) |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Sudden weight gain / loss | <input type="checkbox"/> Sensation of chills /fever |
| <input type="checkbox"/> Low energy/ fatigue | <input type="checkbox"/> Poor / excessive appetite | <input type="checkbox"/> Bitter taste in mouth (especially in the morning) |
| <input type="checkbox"/> General weakness | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Sudden energy drop (time of day?)_____ |
| <input type="checkbox"/> Propensity to catch colds | <input type="checkbox"/> Cravings | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Allergies (food / seasonal) | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Getting car, sea or air sick easily |
| <input type="checkbox"/> Feeling worse after exercise | <input type="checkbox"/> Organ prolapse | |
| <input type="checkbox"/> Difficulty concentrating or staying on task | <input type="checkbox"/> Sensation of heaviness in the body | |
| <input type="checkbox"/> Feeling spacey | <input type="checkbox"/> Strong thirst | |

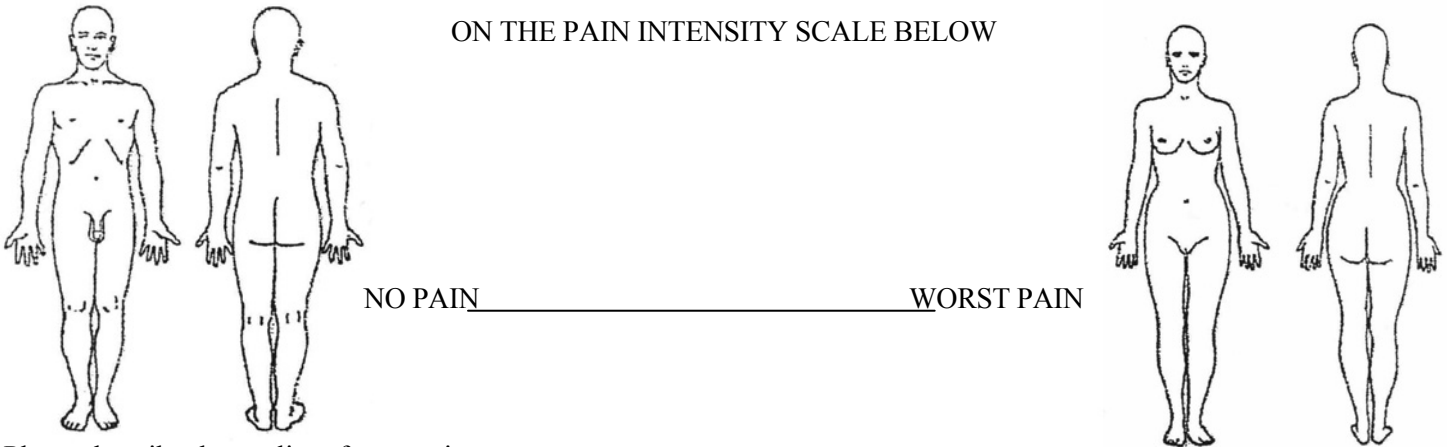
MUSCULOSKELETAL

- | | | |
|---|--|--|
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Stiff shoulders | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Sore / weak / cold knees |
| <input type="checkbox"/> Limited range of motion (where? _____) | <input type="checkbox"/> Hand / wrist pain | <input type="checkbox"/> Foot / ankle pain |
| <input type="checkbox"/> Tingling / numbness | <input type="checkbox"/> Back pain | <input type="checkbox"/> Joint pain (where? _____) |
| | <input type="checkbox"/> Cold low back | |

Any other joint or bone problems? _____

Are you in physical pain right now? Yes No

PLEASE IDENTIFY ANY PAINFUL OR DISTRESSED AREAS AND MARK THE DEGREE OF PAIN ON THE PAIN INTENSITY SCALE BELOW



Please describe the quality of your pain:

- | | | |
|---------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Fixed | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Moving | <input type="checkbox"/> Other _____ |

Do any of the following worsen the pain?

- | | | |
|-----------------------------------|-------------------------------|--------------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Rest | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Cold | <input type="checkbox"/> Other _____ |

Do any of the following lessen the pain?

- | | | |
|-----------------------------------|-------------------------------|--------------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Rest | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Cold | <input type="checkbox"/> Other _____ |

SKIN AND HAIR

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Acne / rosacea | <input type="checkbox"/> Furuncles |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infection |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Moles / warts |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Changes in hair or skin texture |

Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Deviated septum |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Headaches (where? when?) | <input type="checkbox"/> Floaters | <input type="checkbox"/> Nasal congestion |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Post nasal drip |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Itching in the ear | <input type="checkbox"/> Dry throat |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Deafness | <input type="checkbox"/> Itchy throat |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Tinnitus (ringing in the ears) | |

Any other head or neck problems? _____

ORAL DISEASE

- | | | |
|---|--|--|
| <input type="checkbox"/> Periodontitis | <input type="checkbox"/> Stomatitis | <input type="checkbox"/> Tooth sensitivity |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Canker sores | <input type="checkbox"/> Teeth clenching or grinding |
| <input type="checkbox"/> Dental abscesses | <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Pain or clicking of the jaw |

Any other oral problems? _____

RESPIRATORY

- | | | |
|--|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Excessive phlegm (color?) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | |

Any other respiratory problems? _____

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> Fast pulse (over 100 beats/min.) | <input type="checkbox"/> Flushed or red face | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Slow pulse (under 60 beats/min.) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feeling dizzy or faint when getting up quickly or standing for a long time |
| <input type="checkbox"/> Irregular pulse | <input type="checkbox"/> Fainting | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Raynaud's disease | |
| <input type="checkbox"/> Feeling of pressure in the chest | <input type="checkbox"/> Cold hands / feet | |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Swollen hands / feet | |
| <input type="checkbox"/> High / low blood pressure | <input type="checkbox"/> Blood clots | |
| <input type="checkbox"/> Migraines with nausea | <input type="checkbox"/> Varicose veins | |

Any other heart or blood vessel problems? _____

GASTROINTESTINAL

- | | | |
|---|--|--|
| <input type="checkbox"/> Lack of / excessive appetite | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Diarrhea / loose stools | <input type="checkbox"/> Peptic or duodenal ulcers |
| <input type="checkbox"/> Bitter/sour/bland taste in the mouth | <input type="checkbox"/> Constipation / hard or difficult to pass stools | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Feeling incomplete after elimination | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> GI tumors |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Hiccoughs | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Black stools/ blood in stools |
| <input type="checkbox"/> Bloating after meals | | <input type="checkbox"/> Rectal pain or itching |
| <input type="checkbox"/> Insufficient stomach acid | | <input type="checkbox"/> Ileocecal valve spasm |

Any other gastrointestinal problems? _____

GENITOURINARY

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain / burning on urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Prostate gland problems | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Dribbling urination | <input type="checkbox"/> Low libido | |

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

Is your urine: Pale yellow Dark yellow Reddish Clear Cloudy Foamy Scanty Profuse

Any other genital or urinary problems? _____

GYNECOLOGICAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> PMS | <input type="checkbox"/> Recurrent yeast infections |
| <input type="checkbox"/> Lack of periods | <input type="checkbox"/> Menopause | <input type="checkbox"/> Vaginal itch |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Vaginal pain or soreness |
| <input type="checkbox"/> Scanty periods | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Excessive discharge |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Infertility | <input type="checkbox"/> Low libido |

Age at first menses _____ Are you perimenopausal? ____ Are you menopausal? ____ Age at menopause (if applicable) _____

Number of children _____ Number of pregnancies _____ Miscarriages _____ Abortions _____ Premature births _____

Could you be pregnant now? _____ If so, when are you due? _____

Time between cycles (day 1 to 1) _____ Average duration of flow _____ First day of last cycle _____

Color of the flow: Pale red Bright red Dark red Wine Rust Purple Brown

Clots: Small Large Red Purple Black Other _____

Do you experience any of the following symptoms before or during your period?

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Water retention |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Depression | <input type="checkbox"/> Breast tenderness |
| <input type="checkbox"/> Tension headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Breast swelling |

Do you practice birth control? Yes No If so, what type? _____ For how long? _____

Any other gynecological problems? _____

ENDOCRINE DISORDERS

- Overactive thyroid
- Underactive thyroid
- Hyperparathyroidism
- Hypoparathyroidism
- Parathyroid tumor
- Cushing's syndrome
- Addison's disease
- Diabetes
- Pituitary disorder
- Hypoglycemia
- Other _____

Any other hormonal problems? _____

NEUROPSYCHOLOGICAL

- Seizures
- Dizziness
- Loss of balance
- Areas of numbness
- Poor memory
- Lack of coordination
- Concussion
- Anxiety
- Irritability
- Easily susceptible to stress
- Easily scared
- Depression

Have you ever been treated for emotional problems? _____

Has there been any major traumatic experience or loss in your life? _____

Age at the time of trauma _____

Have you ever considered or attempted suicide? Yes No

Any other neurological or psychological problems? _____

AUTOIMMUNE AND INFLAMMATORY CONDITIONS

- Hashimoto's disease
- Systemic lupus erythematosus
- Rheumatic fever
- Rheumatic heart disease
- Rheumatoid arthritis
- Osteoarthritis
- Temporal arteritis
- Polymyalgia rheumatica
- Myofascial pain syndrome
- Fibromyalgia
- Bursitis
- Tendinitis
- Capsulitis
- Tendosynovitis
- Plantar fasciitis
- Glomerulonephritis
- Streptococci infections
- Staphylococci infections
- Ear infections
- Sore throats
- Swollen glands
- Swollen lymph nodes
- Allergies
- Food allergies
- Atopic dermatitis
- Neurodermatitis
- Cellulitis
- Alopecia
- Vulvitis
- Low immunity

Any other autoimmune / inflammatory problems? _____

PLEASE LIST ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS:
