Point of Balance
ACUPUNCTURE & HERBS

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HEALTH HISTORY QUESTIONNAIRE

Welcome to **"Point of Balance - Acupuncture and Herbs"**. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential in conformation with our Privacy Policy. If you have questions, please ask.

Name ____
Street ______________________________ City ____________________ State _____ Zip ____________
Date of birth ___/___/___ Age ______ Occupation ____
Phone (______)_______-______________ e-mail ____
Referred by ________________ Family Physician ___________________ In Emergency Notify ____________

What are the main health concern that you would like to address?

____

____

What kinds of treatment or therapy have you tried?

____

Have you tried acupuncture or Chinese herbal medicine before? Y/N
To what extent does this condition 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 this condition by a physician ? Y/N
If so, what is the diagnosis ____

PAST MEDICAL HISTORY

☐ Allergies ☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ High blood pressure ☐ Heart disease ☐ Seizures ☐ Rheumatic fever
☐ Surgeries ☐ Venereal disease ☐ Thyroid disease ☐ Birth trauma (prolonged labor, forceps delivery, etc.)
Other significant illness (describe) ____

____

Accidents or significant trauma (describe) _______________________________________

____

Other relevant medical history (describe) ____

____

FAMILY MEDICAL HISTORY

☐ Allergies ☐ Diabetes ☐ Asthma ☐ Cancer ☐ Heart disease ☐ High blood pressure ☐ Seizures ☐ Stroke ☐ Other ______

____

OCCUPATION

Occupational stress factors (physical, psychological, chemical) ____________________________

____

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LIFESTYLE

Do you follow a regular exercise program? Y/N

Hours and quality of sleep ________________________________How much water a day do you consume ? ______________

Please check any of the following habits that apply. How much and how often do you use them?

☐ Cigarette smoking ________________ ☐ Coffee, tea or cola ________________ ☐ Alcoholic beverages ________________

☐ Recreational Drugs ________________

List medications taken within the last month (vitamins, drugs, herbs, etc.)

____

____

____

PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS.

GENERAL

☐ Poor appetite ☐ Changes in appetite ☐ Cravings ☐ Weight gain ☐ Weight loss ☐ Sudden energy drop (time of day?)
☐ Disturbed sleep ☐ Insomnia ☐ Night sweats ☐ Sweating easily ☐ Fever ☐ Chills ☐ Localized weakness ☐ Tremors
☐ Bleeding or bruising easily ☐ Recent moles ☐ Nose bleeds ☐ Changes in texture of hair or skin ☐ Recurrent sore throats
☐ Grinding teeth ☐ Jaw clicks ☐ Teeth problems ☐ Sores on lips or tongue ☐ Facial pain ☐ Headaches (where? when?)
☐ Swelling of feet ☐ Blood clots ☐ Difficulty in breathing ☐ Difficulty breathing when lying down ☐ Strong thirst
☐ Excessive phlegm (color ?) ☐ Anxiety ☐ Bad temper ☐ Easily susceptible to stress ☐ cold hands ☐ cold hand and feet ☐
Other unusual or abnormal conditions you have noticed ? (describe) ____

____

MUSCULOSKELETAL

☐ Muscle pain ☐ Muscle weakness ☐ Tingling ☐ Numbness ☐ Neck pain ☐ Back pain ☐ Hip pain ☐ Knee pain ☐ Foot/ankle pain ☐ Shoulder pain ☐ Elbow pain ☐ Hand/wrist pain ☐ Other musculoskeletal condition? (describe) _____________

____

____

PAIN

Location of Pain (other) ____

Severity of Pain 1 2 3 4 5 6 7 8 9 10

Quality of Pain

☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Changing location ☐ Sudden onset ☐ Progressive onset ☐ Radiating pain
☐ Continuous pain ☐ Sporadic pain ☐ better/worse with rest ☐ better/worse with movement ☐ better/worse when starting movement ☐ better/worse with cold ☐ better/worse with heat ☐ better/worse with change of weather ☐ better/worse with pressure ☐ other (describe) ____

____

____

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SKIN AND HAIR

☐ Rash ☐ Ulcerations ☐ Hives ☐ Itching ☐ dry skin ☐ Eczema ☐ Pimples ☐ Dandruff ☐ Hair loss ☐ Other hair or skin changes (describe) ____

HEAD, EYES, EARS, NOSE, THROAT

☐ Eye pain ☐ Glasses ☐ Spots in front of eyes ☐ Poor vision ☐ Night blindness ☐ Blurry vision ☐ Color blindness ☐ Cataracts ☐ Eye strain ☐ Sinus problems ☐ Headache ☐ Migraine ☐ Earache ☐ Ringing in ears ☐ Poor hearing ☐ Sore throat ☐ Other (describe) ____

CARDIOVASCULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Dizziness ☐ Irregular heartbeat ☐ Fainting ☐ Cold hands or feet ☐ Swelling of hands ☐ Numbness of hands ☐ Other cardiovascular condition (describe) ______________

RESPIRATORY

☐ Cough ☐ Coughing up blood ☐ Asthma ☐ Frequent colds ☐ Other respiratory condition (describe) __________

DIGESTIVE

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas ☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Chronic laxative use ☐ Rectal pain ☐ Hemorrhoids ☐ Abdominal pain ☐ Other digestive condition (describe) ___

GENITOURINARY

☐ Painful urination ☐ Frequent urination ☐ Urgency to urinate ☐ Unable to hold urine ☐ Blood in urine ☐ Do you wake up at night to urinate? Y/N If yes how often ? ________☐ Decrease in flow ☐ Kidney stones ☐ Sores on genitals ☐ Impotence
☐ Any particular color to your urine? (describe) ____
☐ Other genitourinary condition ? (describe)______________________________________

GYNECOLOGICAL

Age at first menses ________Time between cycles ________ Duration of bleeding ________Date of last menses _________
Number of pregnancies _______ Age at menopause ________ Do you practice birth control? Y/N
☐ Painful menses ☐ Heavy menstrual flow ☐ Light menstrual flow ☐ Menstrual clots ☐ Irregular menses ☐ Long menses ☐ short menses ☐ Premature births ☐ Miscarriages ☐ Abortions ☐ Infertility ☐ Premenstrual changes (describe) ____________

☐ Other gynecological condition (describe) ____

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Dizziness ☐ Loss of balance ☐ Areas of numbness ☐ Poor memory ☐ Lack of coordination ☐ Concussion ☐ Depression ☐ Seasonal effective disorder ☐ Bipolar disorder ☐ Have you ever been treated for emotional problems? Y/N
☐ Have you ever considered or attempted suicide? Y/N
☐ Any other neurological or psychological problems? (describe) ______________________________

PLEASE LIST ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS

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OFFICE POLICIES

Appointments and Scheduling

• Treatments by appointment only. Emergency appointments are available if there is time in the schedule. Please call.
• Please be on time for appointments.

Fees and Billing

• The fee for acupuncture initial consultation, including treatment, is $120 and follow up visits are $80. Treatments typically last from between 45 minutes to one hour. Rates are subject to change upon notification
• Cancellations are expected to be made 24 hours in advance.
• Payment is requested at the time of visit (check or cash). If you have questions or concerns about these policies please ask.

I have read and agree to the above policies.

Date ____/_____/_____

Signature ____