Point of Balance
ACUPUNCTURE & HERBS

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HEALTH HISTORY QUESTIONNAIRE

Welcome to **"Point of Balance Acupuncture & 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_____Date of birth ____/____/____ Age_____ Occupation _____
Street _____ City _____ State _____ Zip _____
Phone (_____)_____ e-mail _____
Referred by _____ In Emergency Notify _____

MAIN HEALTH CONCERN that you would like to address?

_____

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 _____
Have you tried acupuncture or Chinese herbal medicine before? Y/N
What kinds of treatment or therapy have you tried?

_____

PAST MEDICAL HISTORY

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

_____
_____
_____
_____
_____

OCCUPATION

Occupational stress factors (physical, psychological, chemical) _____

_____

LIFESTYLE

Regular exercise program? Y/N
Water intake a day?_____□ Cigarette smoking_____□ Coffee_____□ Alcoholic beverages _____
Hours and quality of sleep _____
Medications taken within the last month (vitamins, drugs, herbs, etc.)

_____
_____
_____
_____

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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 □ 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) _____

_____

_____

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) _____

_____

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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

_____

_____

_____

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 initial fee for an evaluation and treatment is $120 and $80 per subsequent treatment.
- Treatments typically last between 45 minutes to one hour. Rates are subject to change upon notification.
- Cancellations are expected to be made 24 hours before scheduled appointment.
- Payment is requested at the time of visit **(check or cash).** Insurance is not accepted.

If you have questions or concerns about these policies please ask.

I have read and agree to the above policies.

Date ____/_____/_____ Signature _____