

Evenstar Acupuncture and Integrative Medicine

Health Questionnaire

Please complete this questionnaire carefully. All information will be held in absolute confidence.

Name _____ Date _____
Address _____ Date of Birth ____/____/____ Age ____
City, State, Zip: _____ (P) Cell: _____
Email: _____ (P) Home: _____
Employer _____ Height _____ Weight _____
Occupation _____ Marital Status _____
Emergency contact _____ Emergency phone _____
Referred by: _____

Main Problem(s) _____

Does this problem interfere with daily activities? Please explain. _____

Have you been given a diagnosis for this problem? _____

Personal History: (check all that apply, note history & treatment)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |

Family Medical History (Please identify the family member's relation to you)

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

Surgeries: (Please include date) _____

Significant Trauma: (Describe accidents, falls...with dates, treatment, & results) _____

Medicines taken within the last two months (including OTC vitamins, drugs, herbs...) _____

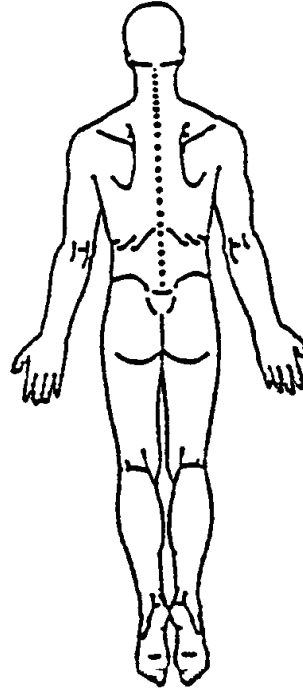
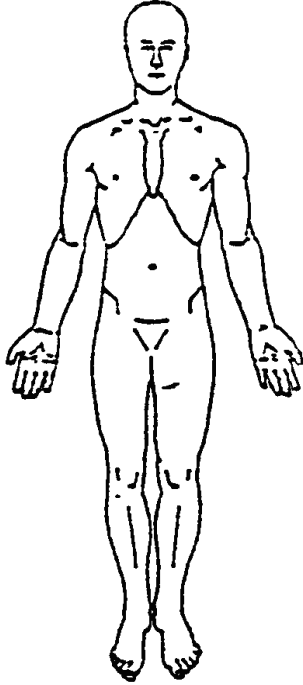
Allergies: (Causes, symptoms, discomforts) _____

How much coffee, tea, or cola do you drink a day? _____ How many cigarettes do you smoke a day? _____

How much alcohol do you drink during a typical week? _____

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Indicate Painful or Distressed Areas. Explain as fully as possible.



Please explain if you have had any of the following within the last 3 months:

GENERAL:

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Changes in Appetite | <input type="checkbox"/> Fevers | <input type="checkbox"/> Poor Sleep / Trouble Sleeping |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Sweating Easily | <input type="checkbox"/> Localized Weakness |
| <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sudden Energy Drop |
| <input type="checkbox"/> Cravings (circle all that apply) sugar salt sour spicy | <input type="checkbox"/> Bleed or Bruise easily | Time of Day _____ |
| | <input type="checkbox"/> Tremors | |

SKIN & HAIR:

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itches | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Change in hair or skin texture | Other _____ | |

CARDIOVASCULAR:

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Swelling in Feet |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in Breathing |
| Other Heart or Circulatory Problems _____ | | |

RESPIRATORY:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with Deep Breaths |
| <input type="checkbox"/> Difficulty Breathing When Lying Down | <input type="checkbox"/> Production of Phlegm - Color? _____ | |
| Other Lung Problems _____ | | |

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HEAD, EYES, EARS, NOSE & THROAT:

- | | | |
|--|--|---|
| <input type="checkbox"/> Recurrent Sore Throats | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Poor Vision |
| <input type="checkbox"/> Sores on Lips or Tongue | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Blurry Vision |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Clicking Jaw | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Concussion(s) | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Glasses | <input type="checkbox"/> Spots in Front of Eyes |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Color Blindness | |

Headaches - where & when _____

Other head or neck problems _____

GASTROINTESTINAL:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramps | Other Stomach or Intestinal Problems _____ | |

GENITO-URINARY:

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Decrease in Urine Flow | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Waking at night to Void - How Often _____ | Color of Urine _____ | |

Other Problems with Genitalia or Urinary System _____

REPRODUCTIVE & GYNECOLOGIC:

- | | | |
|--------------------|---|---|
| Pregnancies _____ | Date of Last menses _____ | <input type="checkbox"/> Irregular Periods |
| Births _____ | Length of Menses _____ | <input type="checkbox"/> No Periods |
| Miscarriages _____ | Days Between Menses _____ | <input type="checkbox"/> Breast Lumps or Pain |
| Abortions _____ | Flow: <input type="checkbox"/> Heavy <input type="checkbox"/> Light | <input type="checkbox"/> Chronic Yeast Infections |
| Last PAP _____ | Clots: <input type="checkbox"/> Dark <input type="checkbox"/> Red | <input type="checkbox"/> Menopause - Age _____ |

Birth Control Type & Length of Use _____

Pain with Cycle: Beginning Ending Ovulation PMS: Psyche Body

Vaginal Discharge/Leukorrhea - please describe _____

MUSCULOSKELETAL:

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot/Ankle Pain |
| <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain |

Other Joint or Bone Problems _____

NEUROPSYCHOLOGICAL:

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Low Tolerance for Stress | |

Have you been treated for emotional problems? _____ Have you considered or attempted suicide? _____