INNER SPACE ACUPUNCTURE

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HEALTH HISTORY QUESTIONAIRE

Name _____ **Date** _____

Chief Concern_____

_____

Other Concerns _____

_____

_____

When did these problems begin? (Be Specific) _____

_____

_____

How do these complaints affect your daily activities? (work, sleep, relationships) _____

_____

_____

Have you been diagnosed? If so, what is the diagnosis? _____

_____

What kinds of treatments have you tried? _____

_____

Are you Pregnant? _____ **Do you have a pacemaker?** _____

Medical History for the past six (6) months (include dates) _____

_____

Family Medical History & significant illness (please circle) Cancer Diabetes Hepatitis Heart Disease High Blood Pressure Stroke Rheumatic Fever Seizures Thyroid Disease Venereal Disease Allergies Asthma Other_____

Surgeries _____

_____

_____

Significant Trauma (auto accidents, injuries, etc.) _____

_____

_____

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Your Birth History (prolonged labor, forceps delivery, etc.) _____

_____

Allergies (drugs, chemicals, foods) _____

_____

Medications taken in the last two (2) months (include vitamins, drugs, herbs, birth control and over the counter) _____

_____

_____

Lifestyle / Occupational Stress (chemical, physical etc.) _____

_____

Do you exercise? _____ **How Regularly**? _____ **Describe** _____

_____

Have you ever been on a restricted diet? _____ **What Kind**? _____

_____

Please describe your average daily diet including meals and snacks:

Morning: _____

_____

Afternoon:_____

_____

Evening: _____

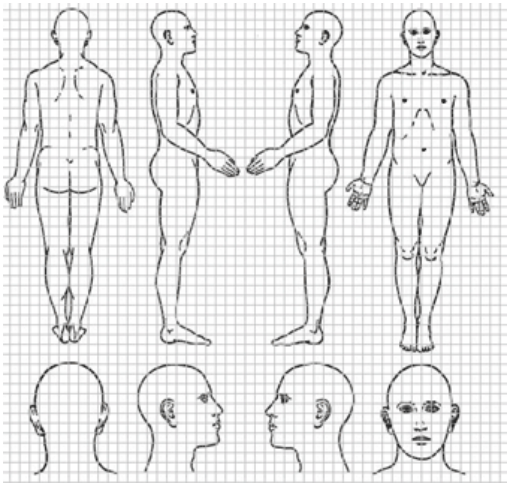
_____

Is there anything else you would like us to know about you? _____

_____

_____

Indicate any painful or distressed areas



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Please check if you have had within the last three (3) months:

_____ Poor appetite	_____ Poor sleeping	_____ Fatigue
_____ Fevers	_____ Chills	_____ Night sweats
_____ Sweats easily	_____ Tremors	_____ Cravings
_____ Localized weakness	_____ Poor balance	_____ Change in appetite
_____ Peculiar tastes or smells	_____ Weight loss	_____ Weight gain

_____ Sudden thirst (cold or hot drinks)

Sudden energy drop (what time of day?) _____

SKIN and HAIR

_____ Rashes	_____ Ulcerations	_____ Hives
_____ Itching	_____ Eczema	_____ Pimples
_____ Dandruff	_____ Loss of hair	_____ Recent moles

_____ Change in hair or skin texture

Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE and THROAT

_____ Dizziness	_____ Concussions	_____ Migraines
_____ Glasses	_____ Eye strains	_____ Eye pain
_____ Poor Vision	_____ Night blindness	_____ Color blindness
_____ Cataracts	_____ Blurry vision	_____ Earaches
_____ Ringing in ears	_____ Poor hearing	_____ Spots in front of eyes
_____ Sinus problems	_____ Nose bleeds	_____ recurrent sore throats
_____ Grinding teeth	_____ Facial pain	_____ Sores on lips or
_____ Teeth problems	_____ Jaw clicks	tongue

HEADACHES? Where and when?_____

Any other head and / or neck problems? _____

CARDIOVASCULAR

_____ High blood pressure	_____ Low blood pressure	_____ Chest pain
_____ irregular heartbeat	_____ dizziness	_____ Fainting
_____ Cold hands or feet	_____ swelling of hands	_____ Swelling of feet
_____ Blood clots	_____ Phlebitis	_____ Difficulty breathing

ANY OTHER HEART OR BLOOD VESSEL PROBLEMS?_____

_____

(over)

RESPIRATORY

____ Cough	_____ Coughing blood	_____ Asthma
____ Bronchitis	_____ Pneumonia	_____ Pain with deep breath

____ Difficulty breathing when lying down

____ Production of Phlegm What color?_____

Any other lung problem? _____

GASTROINTESTINAL

____ Nausea	_____ Vomiting	_____ Diarrhea
____ Constipation	_____ Gas	_____ Belching
____ Black stools	_____ Blood in stools	_____ Indigestion
____ bad breath	_____ Rectal pain	_____ Hemorrhoids

____ Chronic laxative use

Any other problems with your stomach or intestines?_____

GENITO-URINARY

____ Pain on urination	_____ frequent urination	_____ Blood in urine
____ Urgency to urinate	_____ unable to hold urine	_____ Kidney stones
____ decrease in flow	_____ impotency	_____ Sores on genitals

Do you wake up to urinate? How often? _____

Any particular color to your urine? _____

Any other problems with your genitals or urinary system? _____

PREGNANCY & GYNOCOLOGY

____ Number of pregnancies	_____ Number of births	_____ Premature birth
____ Miscarriages	_____ Abortions	_____ Age @ first menses
____ Period between menses	_____ Duration	_____ first day of last menses
____ Unusual character (heavy or light)		_____ Irregular periods
____ Painful periods	_____ Clots	_____ Last PAP
____ Vaginal discharge	_____ Vaginal sores	_____ Breast lumps

____ Changes to body / psyche prior to discharge

Do you practice birth control?____ What type and for how long?_____

MUSCULOSKELATAL

____ Neck pain	_____ Muscle pains	_____ Knee pains
____ back pain	_____ Muscle weakness	_____ Foot/ankle pains
____ Hand/wrist pains	_____ Shoulder pain	_____ Hip pain

ANY OTHER JOINT OR BONE PROBLEMS? _____

(over)

NEUROPSYCHOLOGICAL

_____ Seizures	_____ Dizziness	_____ Loss of balance
_____ Areas of numbness	_____ Lack of coordination	_____ Poor memory
_____ Concussion	_____ Depression	_____ Anxiety
_____ Bad temper	_____ Easily susceptible to stress	

Have you ever been treated for emotional problems?_____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

COMMENTS:

(over)