GRETA WILLIAMS
Acupuncture Family Care

Health History Questionnaire & Contact Information

Welcome to Acupuncture Family Care. Please complete this form as best as possible, as it provides valuable information on how to best support and treat you. Information on this form is **confidential**.

First Name: _____ MI:_____ Last Name: _____ Date: _____

Address _____

City: _____ State: _____ Zip: _____

Cell#:_____ Home #: _____ Work :_____

Email: _____

Occupation: _____ Date of Birth: ___/___/___ Age: _____

Emergency Contact:_____ Contact Phone: _____Relation:_____

Primary Physician _____ Physician's Phone: _____

Referral Information: How did you hear about us? _____

CURRENT HEALTH

What are the main symptoms/ailments you are seeking treatment for - primary & secondary?

_____

_____

_____

Duration, description, pain level (1-10 worse):

_____

_____

Western medical diagnosis?

_____

What treatments have you had in the past for these issues?

_____

Does it interfere with sleep, work, sex, or ability to function?_____

SURGERIES/HOSPITIZATIONS/ACCIDENTS/TRAUMAS:
Please list any previous surgeries, hospitalizations, accidents, and/or traumas with dates:

_____

_____

_____

WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

❑ Diabetes, Type: __ ❑ Stroke/heart attack ❑ Multiple sclerosis
❑ Epilepsy/ seizures ❑ Pacemaker ❑ Parasites/Yeast Issues
❑ Arthritis ❑ Fibromyalgia ❑ Chronic fatigue syndrome
❑ Cancer: what type _____ Date: _____
❑ Anemia ❑ Mental health issues: _____
❑ HIV/AIDS ❑ Hepatitis B ❑ Hepatitis C ❑ TB
❑ Allergies: drugs, metals, adhesives, food, substances (plant, animal, environmental):_____
_____
Other Diagnosis: _____

WESTERN MEDICATIONS

Please list below all of the medications/supplements/herbs you take:
I do not take any: ❑ Western medications ❑ Supplements ❑Herbs

Medication/Supplement/Herb:	**Dosage:**	**Reason:**

Typical Diet:

Breakfast:	**Lunch:**	**Dinner:**

How much water do you drink a day? _____ Caffeinated beverages – amt/type? _____

Alcohol intake per week? _____ Do you smoke? ❑ Yes ❑ No

How is your energy throughout the day: ❑ Abundant ❑ Sufficient ❑ Ups & Down ❑ Low ❑ Exhausted

DIAGNOSTIC QUESTIONS

Please check off symptoms you have experienced **in the last 4 months and/or significant in your health history.**

HEAD, EYES, EARS, NOSE, THROAT:

❑ sinus problems ❑ headaches/migraines ❑ sneezing/runny nose
❑ allergies ❑ dizziness ❑ ear/hearing problems
❑ sore throat/mouth ❑ dental/gum ❑ dry mouth
❑ difficulty swallowing ❑ vision problems ❑ other (specify)_____

SKIN/HAIR/NAILS

- ❑ itchy/painful rashes
- ❑ dry skin
- ❑ shingles
- ❑ psoriasis/eczema
- ❑ mole changes
- ❑ hair loss
- ❑ acne
- ❑ bleed/bruise easily
- ❑ other (specify) _____

RESPIRATORY

- ❑ asthma
- ❑ shortness of breath
- ❑ pain w/deep breath
- ❑ cough
- ❑ frequent colds/low immunity
- ❑ other (specify)_____

CARDIOVASCULAR

- ❑ low blood pressure
- ❑ high blood pressure
- ❑ palpitations/ 'flutters'
- ❑ chest pain
- ❑ other, specify: _____

GASTROINTESTINAL

- ❑ gas/bloating/belching
- ❑ acid reflux
- ❑ indigestion
- ❑ nausea
- ❑ vomiting
- ❑ heartburn
- ❑ constipation
- ❑ diarrhea
- ❑ hemorrhoids
- ❑ weight loss/gain
- ❑ other, specify: _____

SLEEP:

- ❑ insomnia
- ❑ difficulty falling asleep
- ❑ frequent waking
- ❑ dream disturbed sleep
- ❑ night sweats
- ❑ other, specify: _____

GENITO-URINARY

- ❑ frequent urination #___
- ❑ night urination Circle: 1 2 3
- ❑ urinary dribbling
- ❑ low sex drive
- ❑ impotence
- ❑ pain
- ❑ Herpes, warts, other
- ❑ other, specify: _____

MUSCULAR/SKELETAL

- ❑ muscle/joint pain
- ❑ back pain
- ❑ knee pain
- ❑ arthritis
- ❑ tight muscles
- ❑ stiff neck/shoulders
- ❑ pain, tingling or numbness in arms, legs, fingers, toes/ neuropathy
- ❑ other, specify: _____

Location:

NEUROLOGICAL/PSYCHOLOGICAL

- ❑ depression/ anxiety
- ❑ poor concentration
- ❑ irritability/anger
- ❑ disorientation/forgetfulness
- ❑ seizures
- ❑ other mental health disorder_____

Have you been treated for mental health_____

Suicide thoughts/ attempts:_____

GYNECOLOGICAL/OBSTETRICS

Menstrual Cycle:

Age of menarche/first period: _____ Date of last period: _____

# of Days between cycles: _____ # of Days of bleeding: _____

Pre-menstrual symptoms (check off box & circle any relevant information in parentheses):

❑ irritability/anger ❑ crying/sadness ❑ breast tenderness (nipple or breast)

❑ mid-cycle pain ❑ irregular periods ❑ no periods

❑ low back pain ❑ bloating ❑ headaches

(Check off any relevant and circle B = Before D = During E = End) ❑ other _____

❑ menstrual cramps (B, D, E) ❑ heavy menstrual flow ❑ light menstrual flow

❑ spotting (B, D, E) # of Days: _____ ❑ Clots: Size (dime/quarter etc): _____

Discharge:

❑ cervical discharge ❑ vaginal pain/itching ❑ vaginal dryness

❑ yeast infections Do you know when you ovulate? ❑ yes ❑ no

Ob/gyn History:

❑ Fibroids ❑ Endometriosis ❑ Ovarian Cysts

❑ Polycystic Ovaries ❑ Thyroid (hyper or hypo) ❑ Other ob/gyn disorders:

Are you pregnant? ❑ Yes ❑ No ❑ Unknown

Please alert your practitioner if you become pregnant. Your treatment will be modified to support a healthy pregnancy.

Are you in menopause? ❑ Yes ❑ No ❑ Unknown ❑ Hot Flashes

Do you take Hormone Replacement Therapy? ❑ Yes ❑ No ❑ Night sweats

How many pregnancies have you had? _____ Births:_____ Cesareans: _____

Date last pap smear: _____ ❑ NORMAL ❑ ABNORMAL

Last breast exam: _____ ❑ NORMAL ❑ ABNORMAL