JR WELLNESS CONSULTANTS

Health History Questionnaire

Important: Complete this document as throroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they could play a major role in diagnosis and treatment.

All information is strictly confidential.

1. General Patient Information

Date: _____ Name:_____

Address: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Age:_____ Date of Birth: _____ Place of Birth:_____

Guardian (if under 18):_____ Gender: [ ]M [ ] F Height: _____ Weight:_____

Occupation:_____ Past Occupations:_____

Employer:_____ Hobbies:_____

How did you hear about the office?_____

Does anything limit you from care? [ ]Yes [ ]No If Yes, please explain:_____

Other health care providers seen for this condition:_____

Medications (if any):_____

Prescribed by:_____

Treatment:_____

Results:_____

Supplements (if any vitamins, herbs, minerals, etc.):_____

Major Complaint(s), in order of significance to you:

Severe	Moderate	Slight	Normal	
[ ]	[ ]	[ ]	[ ]	1._____
[ ]	[ ]	[ ]	[ ]	2._____
[ ]	[ ]	[ ]	[ ]	3._____

How do these conditions impair your daily activities?_____

Patient Medical History

How was your childhood health?_____

_____

Hospital Visits/Stays:_____

_____

Recent Tests: (please indicate test results and date below)

[ ] Physical [ ] Cholesteral [ ] Prostate [ ] Blood (which?)_____

[ ] HIV/STD [ ] Pap Smear [ ] Mammography [ ] Other_____

Test Results and Date:_____

Check any you have had in the past:

[ ] Diabetes	[ ] Allergies	[ ] Glaucoma	[ ] Rheumatic Fever
[ ] Heart Disease	[ ] CVA (stroke)	[ ] Vein Condition	[ ] Thyroid disorder
[ ] Asthma	[ ] Pneumonia	[ ] Tuberculosis	[ ] Emphysema
[ ] Jaundice	[ ] Measles	[ ] Mumps	[ ] Bleeding disorder
[ ] Meningitis	[ ] Polio	[ ] Chicken pox	[ ] Nervous disorders
[ ] Epilepsy	[ ] Cancer	[ ] Mononucleosis	[ ] High fever
[ ] Hepatitis	[ ] Paralysis	[ ] Migraines	[ ] high blood pressure

[ ] Other_____

Immunizations:_____

Surgeries:_____

Date(s):_____

Family History

Family Member	Alive	Deceased	Present health or cause of death
Father	[ ]	[ ]	_____
Mother	[ ]	[ ]	_____
Spouse	[ ]	[ ]	_____
Children	[ ]	[ ]	_____
Brother	[ ]	[ ]	_____
Sister	[ ]	[ ]	_____
Other	[ ]	[ ]	_____

Where are you in the birth order? [ ] first [ ] last [ ] middle [ ] only

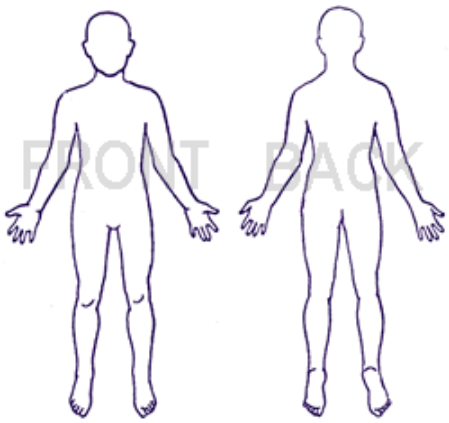
Check the following that have occurred in your blood relatives:

[ ] Diabetes [ ] Cancer [ ] Heart Disease [ ] High Blood Pressure
[ ] Allergies [ ] Tuberculosis [ ] Obesity [ ] Bleeding tendency
[ ] Kidney disease [ ] Alcoholism [ ] Mental Illness [ ] Stroke
[ ] Other_____

Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars. Is the pain:

[ ] Sharp [ ] Burning [ ] Aching
[ ] Cramping [ ] Dull [ ] Moving
[ ] Fixed [ ] Other:_____



Do the following lessen the pain?

[ ] Pressure [ ] Cold [ ] Heat
[ ] Exercise [ ] Other:_____

Do the following worsen the pain?

[ ] Pressure [ ] Cold [ ] Heat
[ ] Other:_____

Please Check the following that pertain to you

Overall Temperature (Kidney Function):

[ ] Cold hands/feet
[ ] Sweaty hands/feet
[ ] Hot/cold body temperature (sensation)
[ ] Afternoon flushes
[ ] Night sweats
[ ] Heat in the hands, feet and chest
[ ] Hot flashes any time of day
[ ] Thirsty
[ ] Perspire easily
[ ] Chest pain traveling to shoulder
[ ] Frequent dreams
[ ] Wake un-refreshed
[ ] Drink coffee (# cups per week:_____)

Eyes (Liver Function)

[ ] Itchy
[ ] Bloodshot
[ ] Hot
[ ] Dry
[ ] Watery
[ ] Gritty
[ ] Blurry Vision

Spleen Function:

[ ] Low appetite
[ ] Abrupt weight gain/weight change
[ ] Abdominal bloating/gas
[ ] Gurgling noise in the stomach
[ ] Fatigue after eating
[ ] Prolapsed organs (previously diagnosed)
which organ?_____
[ ] Easily bruised
[ ] Snoring

Lung Function

[ ] Nasal discharge (Color:_____)
[ ] Cough
[ ] Nose bleeds
[ ] Sinus congestion
[ ] Dry mouth/throat/nose
[ ] Dry skin
[ ] Sore Throat
[ ] Sneezing
[ ] Allergies (To what?_____)
[ ] Alternating fever and chills
[ ] Headaches (Location:_____)

[ ] Decreased night vision
[ ] Near Sighted
[ ] Far Sighted

Kidney, Urinary Blader Function

[ ] Frequent cavities
[ ] Easily broken bones
[ ] Sore knees/weak knees
[ ] Cold sensation in the knees
[ ] Excessive hair loss
[ ] Low-pitched ringing in the ears
[ ] Kidney stones
[ ] Bladder infection
[ ] Lack of bladder control
[ ] Wake during the night to urinate
[ ] Over-thinking
[ ] Worry

Overall Energy (Lung, Kidney function):

[ ] Shortness of breath
[ ] Difficluty keeping eyes open in the daytime
[ ] Easily catches cold
[ ] Low energy
[ ] Feel worse after exercise

Blood (Liver, Spleen, Heart function):

[ ] Dizziness
[ ] See floating black spots

Heart Function

[ ] Palpitations
[ ] Anxiety
[ ] Sores on the tip of the tougue
[ ] Restlessness
[ ] Mental confusion
[ ] Belching
[ ] Hiccoughs
[ ] Stomach pain
[ ] Vomiting

Liver, Gall Bladder functions

[ ] Alternating diarrhea and constipation
[ ] Chest pain
[ ] Tight sensation in the chest
[ ] Bitter taste in the mouth
[ ] Irritable
[ ] Anger easily
[ ] Frustration
[ ] Depression
[ ] Frequently unable to adapt to stress
(what causes the stress?)_____

[ ] Overall achy feeling in the body
[ ] Stiff neck
[ ] Stiff shoulders
[ ] Difficulty Breathing
[ ] Smoke cigarettes (# per day:_____)
[ ] Memory Problems
[ ] Smoked in past?
[ ] Low back pain
[ ] Fear/easlity startled

Stomach Function

[ ] Buring sensation after eating
[ ] Large appetite
[ ] Bad breath
[ ] Mouth (canker) sores
[ ] Bleeding, swollen or painful gums
[ ] Heartburn
[ ] Acid regurgitation
[ ] Ulcer (diagnosed)
[ ] Hemorrhoids
[ ] Lack of perspiration
[ ] Take water to bed

Spleen, Stomach, Large & Small Intestine Function

[ ] Loose stools
[ ] Imcomplete
[ ] Diarrhea
[ ] Blood in stools
[ ] Mucous in stools
[ ] Undigested food in stools

Dampness trapped in the body:

[ ] General sensation of heaviness in the body
[ ] Mental heaviness/sluggishness/fogginess
[ ] Swollen hands/feet
[ ] Swollen joints
[ ] Chest congestion
[ ] Nausea

Urine

[ ] Normal color
[ ] Dark Yellow
[ ] Clear
[ ] Reddish
[ ] Cloudy
[ ] Scanty
[ ] Profuse
[ ] Strong odor
[ ] Burning
[ ] Painful
[ ] Discharge
[ ] Difficult
[ ] Painful
[ ] Urgent

[ ] Skin Rashes [ ] Headache at the top of the head [ ] Tingling sensation or numbness
[ ] Muscle spasms, twitches or cramps [ ] Seizures or convulstions [ ] Lump in the throat
[ ] Neck tension [ ] Limited Range of Motion, Neck
[ ] Shoulder Tension [ ] Limited Range of Motion, Shoulder

[ ] Drink alcohol (Which?_____ How much per week?_____)
[ ] Recreational Drugs (Which?_____ How much per week?_____)
[ ] High-pitched ringing in the ears [ ] Gall stones ([ ] history or [ ] current?)
[ ] Sexually transmitted desease (Which?_____)

Women only

Regular menstrual cycle [ ] Y [ ] N
Number of children:_____
Age of first menstration:_____
Average number of days of flow:_____

Pregnant? [ ] Y [ ] N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire cycle:_____

	Severe	Moderate	Slight	Normal
Vaginal Discharge	[ ]	[ ]	[ ]	[ ]
Bleeding Between Periods	[ ]	[ ]	[ ]	[ ]

Do you experience any of the following syndromes?

[ ] nausea [ ] food cravings [ ] depression [ ] vomiting [ ] headaches
[ ] irritability [ ] water retention [ ] migraines [ ] anxiety [ ] breast swelling
[ ] breast tenderness [ ] dull pain, where?_____ [ ] sharp pain, where?_____
[ ] other emotions/other sx:_____

Please fill in the following menstrual chart, even if you do not have periods. (Put a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men Only:

	Severe	Moderate	Slight	Normal
[ ] Swollen testes	[ ]	[ ]	[ ]	[ ]
[ ] Testicular pain	[ ]	[ ]	[ ]	[ ]
[ ] Impotence	[ ]	[ ]	[ ]	[ ]
[ ] Premature ejaculation	[ ]	[ ]	[ ]	[ ]
[ ] feeling of coldness or numbness in external genitalia	[ ]	[ ]	[ ]	[ ]
[ ] Other_____	[ ]	[ ]	[ ]	[ ]

Other Comments:_____
_____

Patient Signature: _____ Date: _____

Acupuncturist Signature: _____ Date: _____