KNOLL Acupuncture
PROVEN HEALTHCARE SOLUTIONS FOR ACTIVE LIVES©

Health History Questionnaire
(Information For Your Acupuncturist)

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they play a major role in diagnosis and treatment. All information is strictly confidential.

General Patient Information:

Date: ___/____/____

Name: _____

Address:_____

Home Phone: _____Work Phone: _____

Cell: _____ Email Address: _____

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

Guardian (if under 18): _____

Gender: ☐M ☐F Height: ____' ____" Weight: _____lbs.

Occupation: _____Employer: _____

Emergency Contact: Name_____ Relationship_____ Phone:_____

How did you hear about our office?_____

Other physicians/therapists seen for this condition? _____

_____

Medications: (if any)_____

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

_____

Major Complaint(s) in order of significance to you:	Severe	Moderate	Slight
1.			
2.			
3.			
4.			
5.			

How do these conditions impair you daily activities? _____

_____

How was your childhood health?_____

Hospital Visits/Stays: _____

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

☐Physical ☐Cholesterol ☐Pap Smear ☐Blood (which?)

☐HIV/STD ☐Prostate ☐Mammography ☐Other

Test Results and Date:

_____

Check any you have had in the past:

☐ Heart Disease	☐ Lung disease	☐ Glaucoma	☐ Diabetes
☐ CVA (stroke)	☐ Emphysema	☐ Thyroid disorder	☐ Chicken Pox
☐ Vein condition	☐ Asthma	☐ Tuberculosis	☐ Shingles
☐ Rheumatic Fever	☐ Pneumonia	☐ Jaundice	☐ Measles
☐ Bleeding Tendency	☐ Allergies	☐ Liver disease	☐ Mumps
☐ Heart disease	☐ High Fever	☐ Meningitis	☐ Gonorrhea
☐ High blood pressure	☐ Syphilis	☐ Hepatitis	☐Mononucleosis
☐ HIV	☐ Epilepsy	☐ Nervous System Disorder_____	
☐ Cancer	☐ Kidney disease	☐ Multiple Sclerosis_____	
☐ Polio		☐ Migraines_____	
☐ Paralysis		☐ Other: _____	

Immunizations: _____

Surgeries: _____

Family Member	Alive	Deceased	Present Health/Cause of death
Father			
Mother			
Spouse			
Sister			
Brother			
Child			
Child			
Child			
Child			

Where are you in the birth order: ___first, ___ last, ___ middle, ___ only

Check the following that have occurred in your blood relatives:

☐ Diabetes ☐ Cancer ☐ High Blood Pressure
☐ Allergies ☐ Tuberculosis ☐ Heart Disease
☐ Kidney Disease ☐ Obesity ☐ Bleeding Tendency
☐ Alcoholism ☐ Mental Illness ☐ Stroke
☐ Nervous System Disease ☐ Other _____

Current Condition

Is the pain: ☐Sharp Burning ☐ Aching ☐Cramping
☐Dull Moving ☐Fixed ☐ Other:_____

Do the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise
☐ Other: _____

Please check all conditions that currently pertain to you.

	Overall Temperature (Kidney function) __ Cold hands __ Cold fingers __ Cold feet __Cold toes __ Sweaty hands __ Sweaty feet __ Hot body temperature (sensation) __ Cold body temperature (sensation) __ Afternoon flushes __ Night sweats __ Heat in the hands, feed and chest __ Hot flashes any time of the day __Thirsty __ Perspire easily __ Lack of perspiration __ Take water to bed Overall blood (Liver, Spleen, Heart) __ Seeing floating black spots		Overall energy (Lung, Kidney function) __ Shortness of Breath __ Difficulty keeping eyes open in the day __ General weakness __ Easily catch cold __ Low energy __ Feel worse after exercise Heart function: __ Anxiety __ Palpitations __ Sores on the tip of the tongue __ Restlessness __ Mental confusion __ Chest pain traveling to the shoulder __ Frequent dreams __ Wake un-refreshed __ Drink coffee (# cups per day:___)

	__ Dizziness Spleen Function: __ Low appetite __ Abrupt weight gain __ Abrupt weight loss __ Abdominal bloating __ Abdominal gas __ Gurgling noise in the stomach __ Fatigue after eating __ Prolapsed organs (previously diagnosed/ which organs _____) __ Easily bruised __ Hemorrhoids __ Pensive __ Over-thinking __ Worry		Spleen, Stomach, Large Intestine, Small Intestine function: __ Loose stools __ Constipated __ Incomplete bowel movement __ Diarrhea __ Blood in the stools __ Mucous in the stools __ Undigested food in the stools
	Lung function: __ Nasal discharge (Color:_____) __ Cough __ Nose bleeds __ Sinus congestion __ Dry mouth __ Dry throat __ Dry nose __ Dry skin __ Allergies(List: _____) __ Alternating fever and chills __ Sneezing __ Headache Location:_____) __ Overall achy feeling in the body __ Stiff neck __ Stiff shoulders __ Sore throat __ Difficulty breathing __ Smoke cigarettes (# of cigarettes per day:_____) __ Sadness/Grief __ Melancholy		Dampness Trapped in the Body: __ General sensation of heaviness in the body __ Mental heaviness __ Mental sluggishness __ Mental fogginess __ Swollen hands __ Swollen feet __ Swollen joints __ Chest congestion __ Nausea __ Snoring

	Eyes (Liver Function): __ Itchy __ Bloodshot __ Hot __ Dry __ Watery __ Gritty __ Blurry vision __ Decrease night vision __ Near-sighted __ Far-sighted		Stomach Function: __ Burning sensation after eating __ Large appetite __ Bad breath __ Mouth (canker) sores __ Bleeding, swollen or painful gums __ Heartburn __ Acid regurgitation __ Ulcer (diagnosed) __Belching __ Hiccoughs __Stomach pain __ Vomiting
	Kidney, Urinary Bladder Function: __ Frequent cavities __ Easily broken bones __ Sore knees __ Weak knees __ Cold sensation __ In the knees __ Low back pain __ Memory problems __ Excessive hair loss __ Low-pitched ringing in the ears __ Kidney stones __ Bladder infections __ Wake during the night twice or more to urinate __ Lack of bladder control __ Fear __ Easily startled		Urination: __ Normal color __ Dark yellow __ Clear __ Reddish __ Cloudy __ Scanty __ Profuse __ Strong odor __ Burning __ Painful __ Discharge __ Difficult __ Painful __ Urgent

	Liver, Gall Bladder Function: __ Alternating diarrhea and constipation __ Chest pain __ Tight sensation in the chest __ Bitter taste in the mouth __ Anger easily __ Frustration __ Depression __ Irritability __ Frequently unable to adapt to stress What causes the **stress**? _____ _____ __ Skin rashes __ Headache at the top of the head __ Tingling sensation __ Numbness __ Muscle spasms __ Muscle twitching __ Muscle cramping __ Seizures		Libido: __ Normal __ High __ Low

Men Only:

__ swollen testes __ testicular pain __ impotence __ premature ejaculation

__ feeling of coldness or numbness in the external genitalia

other_____

Women Only:

Regular menstrual cycle? ___Y___N Pregnant? ___Y___N

Number of children: ___ Number of pregnancies: ___

Age of first menstruation: ___ Age of menopause (if applicable):___

Average number of days of flow: ___ Average number of days of entire cycle: ___

Vaginal discharge ___ Y ___N Bleeding between periods ____Y ___N

Regular menstrual cycle? ___Y___N Pregnant? ___Y___N

Please fill in the following menstrual chart:

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