

Durango Community Acupuncture

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Acupuncture

Chinese Herbal Medicine

Qi Gong

Asian Bodywork

Welcome to **Durango Community Acupuncture (DCA)**, **where your health is the point**. It is an honor to serve you in your healthcare needs.

Below is a **Confidential Health History Questionnaire** to fill out prior to your first visit. The questions are meant to give me a sense of how all the systems in the body are working

I look forward to this journey of health and wellness with you.

PRINTED NAME

PHONE NUMBER (with area code)

EMAIL ADDRESS*

*Please provide your email address only if you wish to be included on our newsletter / mailing list.

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 may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Date: ____/____/____ Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

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

Guardian (if under 18): _____

Gender: M F Height: ____ ft. ____ in. Weight: ____ lbs.

(complete if using Insurance)

Social Security Number: ____ - ____ - _____

Driver's Licence # (and State): _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: ____ Zip: _____

Does anything limit you from care? Y N If yes, explain: _____

How did you hear about our office? _____

Other physicians / therapists seen for this condition: _____

Medications (if any): _____

Prescribed by: _____

Treatment: _____

Results: _____

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

	Severe	Moderate	Slight	Normal	Please describe:
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do these conditions impair your daily activities? _____

II. Patient Medical History

How was your childhood health? _____

Hospital visits/stays: _____

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

- | | | | |
|-----------------------------------|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate | <input type="checkbox"/> Blood (which?) |
| <input type="checkbox"/> HIV/STD | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Mammography | <input type="checkbox"/> Other: _____ |

Test Results and Date: _____

Check any you have had in the past:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High fever | <input type="checkbox"/> Migraines | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other heart illnesses | <input type="checkbox"/> Other kidney illnesses |
| <input type="checkbox"/> Other lung illnesses | <input type="checkbox"/> Other liver illnesses | <input type="checkbox"/> Other stomach illnesses | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other spleen illnesses | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever | _____ |

Immunizations: _____

Surgeries: _____

III. Patient Profile

Use the diagrams to clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

- | | | |
|-----------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Aching | _____ |

Do the following lessen the pain?

- | | | |
|-----------------------------------|-------------------------------|---------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Heat | _____ |

Do the following worsen the pain?

- | | | |
|-----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Heat | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Exercise | _____ |

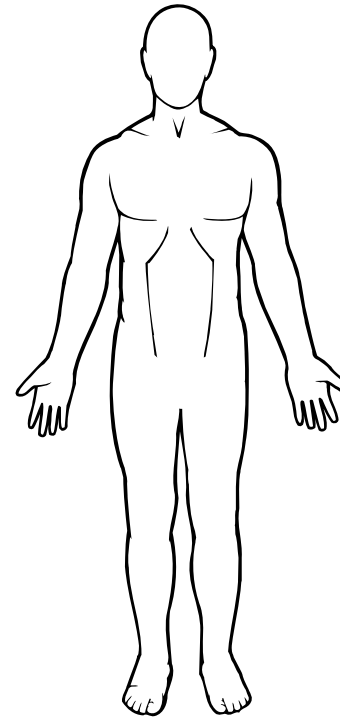
Please check the following that pertain to you:

Overall Temperature (Kidney function):

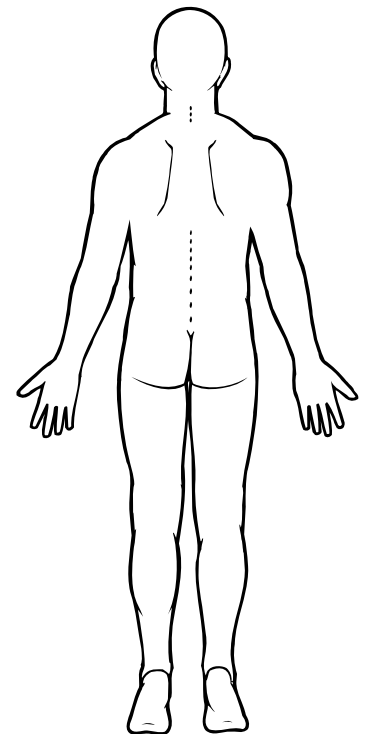
- Cold hands
- Cold feet
- Sweaty hands
- Sweaty feet
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed
- Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney function):

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise



Front



Back

Blood (Liver, Spleen, Heart function):

- Dizziness
- See floating black spots

Heart function:

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake un-refreshed
- Drink coffee (# of cups per week: _____)

Lung function:

- Nasal discharge (Color: _____)
- Cough
- Nose bleeds
- Sinus congestion
- Dry mouth
- Dry throat
- Dry nose
- Dry skin
- Allergies (To what? _____)
- 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
- Melancholy

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 organ? _____)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

- Loose
- Constipated
- Incomplete
- 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
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Stomach functions:

- 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

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
- Convulsions
- Lump in the throat
- Neck tension
- Limited Range-of-motion, Neck
- Shoulder tension
- Limited range-of-motion, shoulder
- Drink alcohol
- Recreational drugs (Which? _____ ,
How much per week? _____)
- High-pitched ringing in the ears
- Gall stones (history of, or currently experiencing)
- Sexually transmitted disease (Which? _____)

Eyes (Liver function):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

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:

- | | | |
|---------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Scanty | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Profuse | <input type="checkbox"/> Difficult |
| <input type="checkbox"/> Clear | <input type="checkbox"/> Strong odor | <input type="checkbox"/> Urgent |
| <input type="checkbox"/> Reddish | <input type="checkbox"/> Burning | <input type="checkbox"/> Frequent |
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Painful | |

Libido:

- Normal High Low

Other symptoms: _____

Women only:

- | | |
|--|---|
| Regular menstrual cycle? <input type="checkbox"/> Y <input type="checkbox"/> N | Average number of days of entire cycle: _____ |
| Number of children: _____ | Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N |
| Age of first menstruation: _____ | Number of pregnancies: _____ |
| Average number of days of flow: _____ | Age of menopause (if applicable): _____ |

- | | | | | |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Severe | Moderate | Slight | Normal |
| Vaginal discharge: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding between periods: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you experience any of the following premenstrual syndromes?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Breast swelling | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other emotions: _____ |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression | <input type="checkbox"/> Dull pain? Where? _____ | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Water retention | _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Sharp pain? Where? _____ | _____ |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Vomiting | _____ | _____ |

Please fill in the following menstrual chart: (put in 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of coldness or numbness in external genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other Comments: _____

Medication Log / Supplements (if any vitamins, herbs, minerals, etc.)

Name: _____ Date: _____

Medication	Dosage	Condition Taken For

IV. Family History

Family Member	Alive	Deceased	Present health or cause of death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____

Where are you in the birth order? First Last Middle Only

Check the following that have occurred in your blood relatives:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Obesity | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Nervous illness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding tendency | |

IV. Family Health History (cont'd)

Name: _____ Date: _____

Condition	Father	Mother	Brother	Sister	Child	Child	Child
Current Age:							
Arthritis							
Asthma							
Hay Fever							
Back Trouble							
Bursitis							
Constipation							
Diabetes							
Neck Pain							
Joint Pain							
Emotional Problems							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
Insomnia							
High Blood Pressure							
Kidney Trouble							
Liver Trouble							
Migraine							
Nervousness							
Pinched Nerve							
Stomach Trouble							
Other							

If any of the above family members are deceased, please list their age at death and cause: _____
