



Health Questionnaire

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: _____ Zipcode: _____

E-Mail Address: _____

Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Birthplace: _____

Guardian (if under 18): _____

Gender [] M [] F Height: _____' _____" Weight: _____ lbs

Occupation: _____ Employer: _____

Other treatment sought for this condition: _____

Medication(s) (if any): _____

Supplements you
take: _____

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

	Severe	Moderate	Slight	Normal	
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"/>	_____
<hr/>					
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	<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)
 Physical Cholesterol Prostate Blood (which?)
 HIV/STD Pap smear Mammography
 Other: _____

Test Results and Date: _____

Check any you have had in the past:

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

Immunizations: _____

Surgeries: _____

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

IV. Patient Profile

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

Is the pain:

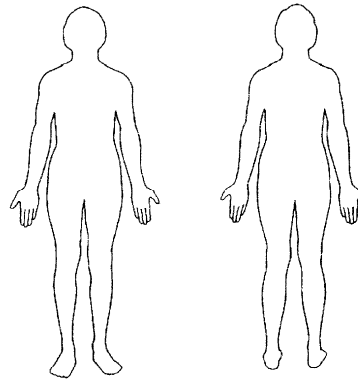
- | | | |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input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

Do the following lessen the pain?

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

Do the following worsen the pain?

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



Front

Back

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
- 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 unrefreshed
- 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 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

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 or current)
- 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:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful

- Discharge
- Difficult
- Painful
- Urgent
- Frequent

Libido:

- Normal
- High
- Low

Other symptoms: _____

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: _____
cycle: _____

Average number of days of entire cycle: _____

	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 pre-menstrual syndromes?

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