Integrated Holistic Medicine Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the comments section. Thank you.

Name:____ Today's Date:________________________

Address:__________________________________City:_______________________State:______Zip:________________

Phone:_______________________________ E-Mail:____

Occupation:________________________ Marital Status:_____________ Family Physician:____________________

Emergency Contact:______________________________ Phone: ______________________________________

Referred by: ______________________________ Insurance Provider: _____________________________________

Age: _______ Height: ______ Weight: ______ Blood Pressure: ________ Heart Rate:______ Dominant Hand:______

Date of Birth: ___________ Time of Birth:_______ City of Birth:____________________________ V ____ P____ K____

Office Use Only

Do you have any electronics in your body (ex. pacemaker)? ☐ Yes ☐ No

Please list any pharmaceutical medicines you take along with the date you began taking that medication and the current dose.

Pharmaceutical	Dose
/ / /	
/ / /	
/ / /	
/ / /	
/ / /	

Pharmaceutical	Dose
/ / /	
/ / /	
/ / /	
/ / /	
/ / /	

Have you noticed any negative side effects with your conventional medications? ☐ Yes ☐ No

Please Describe:

____

____

Please list any health supplements you take along with the dose:

Supplement	Dose

Supplement	Dose

Main problem(s) you would like us to help you with:

____

____

When did you first notice your symptoms? ____

Have you tried acupuncture or Chinese traditional herbal medicine before? ☐ Yes ☐ No

Have you been given a diagnosis for the problem? If so, what and by whom?_________________________

What kinds of treatments have you tried? ____

What response/result did you have? ____

PAST MEDICAL HISTORY QUESTIONS

Significant Illnesses (please include dates)		
__Cancer ____/____/____	__Hepatitis____/____/____	__High Blood Pressure____/____/____
__Heart Disease____/____/____	__Seizures____/____/____	__Rheumatic fever____/____/____
__Thyroid Disease ____/____/____	__Diabetes____/____/____	__Venereal Disease____/____/____

Other:____

Surgeries:____

Significant Emotional or Physical trauma:____

Birth History (prolonged labor, forceps delivery, etc.):____

Allergies:____

Other relevant medical history:____

____

FAMILY MEDICAL HISTORY QUESTIONS

Significant Illnesses (please include family member)		
__Cancer___________________	__Asthma___________________	__High Blood Pressure_____________
__Heart Disease______________	__Seizures___________________	__Diabetes_______________________
__Stroke ____________________	__Allergies__________________	

LIFESTYLE QUESTIONS

Occupation:____

Stress Factors/Occupational Hazards (physical, psychological, chemical, etc.)____________________________

Do you have a regular exercise program? ☐ Yes ☐ No

If yes, please describe:____

Have you ever been on a restricted diet? ☐ Yes ☐ No

If yes, please describe:____

Please describe your average daily diet:

Please describe your average daily diet	
Morning	
Afternoon	
Evening	

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes a day? _________

How many cups (8oz) of coffee per week?_____ Tea per week?______ Soda per week?_____

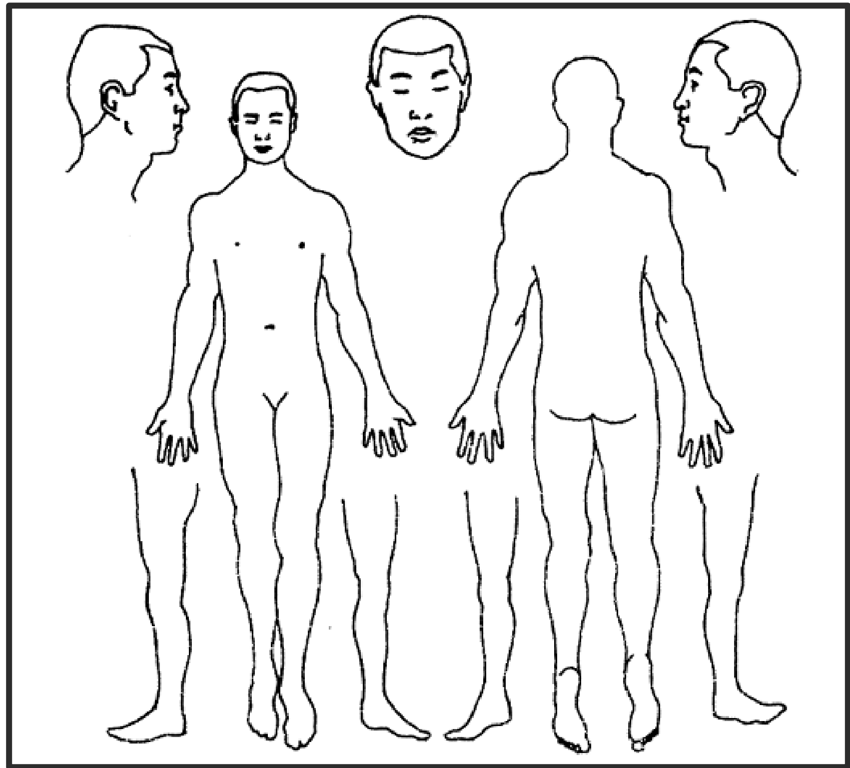
How many cups of water do you drink per DAY?______

Please describe any use of drugs for non-medical purposes, current or past:______________________________

____

PLEASE INDICATE PAINFUL OR DISTRESSED AREAS:

Symbol	Reaction
Pain on pressure	
X	Little
Xx	Moderate
Xxx	Strong
Swelling	
^	Slight
^^	Moderate
^^^	Sever
Tension/weakness	
~	Weak
=	Tense
Spontaneous Pain	
*	Slight
**	Moderate
***	Severe
Pulsing	
O	Slight
OO	Moderate
OOO	Severe
Temperature	
-	Cold
+	Hot
Physical	
@	Sores
#	Rashes
-><-	Spasms



GENERAL HEALTH

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.

Fatigue		Localized Weakness		Bodily Heaviness		Disturbed Sleep		Chills		Desire for Hot Drinks	
Weight Loss		Sudden Energy Drop		Heavy Sleep		Night Sweats		Peculiar Taste		Desire for Iced Drinks	
Weight Gain		Bleed or Bruise easily		Poor Sleep		Cravings					
Poor Appetite		Cold Hands & Feet		Poor Balance		Fever/ Feeling of Heat					

Any other abnormal conditions general health conditions: ____

MUSKULOSKELETAL

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Neck Pain		Knee Pain		Shoulder pain		Muscle Pain		Leg pain		Numbness	
Upper Back Pain		Mid Back Pain		Hip Pain		Muscle Weakness		Headaches/ Migraine			
Low Back Pain		Foot/Ankle Pain		Disc Pain/Problems		Limited Range of Motion		Sciatica			
Elbow Pain		Hand/Wrist Pain		Fibromyalgia		Hand Pain		Arthritis			

Any other joint or bone problems: ____

GASTROINTESTINAL

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Nausea		Indigestion		Acid Regurgitation		Blood in Stools		Rectal Pain		Abdominal Cramps	
Vomiting		Gas		Constipation		Diarrhea		Hemorrhoids		Chronic Laxative Use	
Belching		Bloating after meals		Loose Stools		Bad Breath		Abdominal Pain		Mucus in Stools	

Any other head or gastrointestinal issues: ____

HEAD, EYES, EARS, NOSE AND THROAT

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Dizziness/ Vertigo		Eyesight getting worse		Cataracts		Earaches		Facial Pain		Migraines	
Recurrent Sore Throat		Swollen Glands		TMJ		Sinus Problems		Teeth Problems			
Excessive Saliva		Lumps in Throat		Eye Pain/ Strain		Gum Problems		Jaw Clicks			
Dry Mouth		Enlarged Thyroid		Itchy/ Red Eyes		Sores on Lips/Tongue		Headaches			

Details of when and where headache pain occur: ____________________________________

Any other head or neck issues: ____

GENITO-URINARY

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Pain on Urination		Unable to hold urine		Decrease in Flow		Sores on Genitals		High Libido		Incomplete Urination	
Urgency to Urinate		Kidney Stones		Sexually Transmitted Disease		Impotency		Low Libido		Premature Ejaculation	
Frequent Urination											

Any other genito-urinary issues: ____

CARDIOVASCULAR

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
High Blood Pressure		Chest Pain		Irregular heart Beat		Fainting		Swelling of hands		Blood Clots	
Tachycardia		Low Blood Pressure		Dizziness		Cold hands/feet		Swelling of Feet		Shortness of Breath	

Any other cardiovascular Issues:_ ____

RESPIRATORY

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Cough: Wet		Cough: thin		Postnasal Drip		Difficulty breathing when lying down		Bronchitis		Shortness of breath	
Cough: Dry		Coughing up blood		Tight Chest		Pneumonia		Pain on deep breathing			
Cough: thick		Phlegm*		Asthma/ wheezing		Allergies**					

* What color?________________ **Allergic to what?__________________________________

Any other lung problems: ____

SKIN, HAIR AND NAILS

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Rashes		Bruise easily		Eczema		Loss of Hair		Nail Breakage		Itching	
Psoriasis		Hives		Pimples		Acne					

Any other hair skin or nail problems: ____

REPRODUCTIVE & GYNECOLOGICAL

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Light Flow		Painful periods/ cramps		PMS		Vaginal Sores		Vaginal Odor		Heavy Flow	
Clots		Irregular Periods		Breast Lumps		Vaginal Discharge					

# of Pregnancies	________	# of Days in Menstrual Cycle	________
# of Births	________	1st Day of last period	________
# of Premature Births	________	Duration of periods (# of days)	________
# of Miscarriages	________	Date of last PAP test	________
# of abortions	________	Age Menopause began	________
Age Menses Began			

Changes in body/psyche prior to menstruation:____________________________________

Do you use birth control? ☐ Yes ☐ No

If yes, what method?________________________ If on the birth control pill, how long?__________

NEUROPSYCHOLOGICAL

If you have had any of the following symptoms in the past 6 months, please place a check in the column to the right of the symptom.											
Dizziness		Concussion		Bad Temper		Depression		Abuse Survivor		Easily Stressed	
Loss of Balance		Anxiety		Lack Coordination		Nervous Tics					
Poor Memory		Easily Irritated		Areas of Numbness		Seeing a Therapist					

Have you ever been treated for emotional problems? ☐ Yes ☐ No

If yes, please describe:____ Dates?____________

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Any other neurological or psychological problems?______________________________________

COMMENTS

Please tell us about any other problems you would like to discuss: ______________________________

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Patient's Wish List:

a.______________________________

b.______________________________

c.______________________________

d.______________________________

e.______________________________

f.______________________________

g.______________________________

h.______________________________

i.______________________________

j.______________________________