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Patient Health History Questionnaire

Important: 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 holistic diagnosis and treatment. ***All information is strictly confidential***.

General Information:

Name: _____ Date: _____

Address:_____ City, State, Postal Code: _____

Home Phone: _____ email _____

Cell Phone: _____May we contact you: ☐ at home, ☐ at cell, ☐ email

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

Gender:_____ ☐ Married ☐ Single ☐ Name of Insured if applicable:_____

Height: ____'____" Weight:_____lbs. Insurance Company:_____

Primary Insured Name:_____ Primary Insured DOB:_____

Occupation:_____Employer:_____

Hours worked/week _____ Is your health complaint related to work? ☐ Yes ☐ No ☐ Maybe

How did you hear about our office?_____

Person to notify in an emergency_____ Relationship to you _____

Best contact phone for emergency contact person _____

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

1._____

2._____

3._____

Do any of these conditions impair your daily activities?_____

Patient Medical History

How was your childhood health?_____

Any extended Hospital Visits/Stays:_____

Check any that apply in the past or currently:

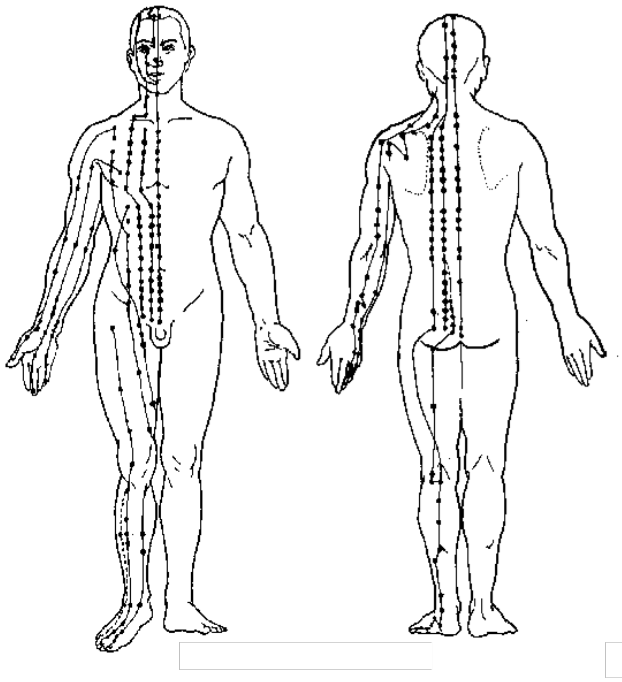
☐ Diabetes	☐ Anemia	☐ CVA (stroke)	☐ Mumps
☐ Heart Disease	☐ Rheumatic Fever	☐ Pneumonia	☐ Chicken pox
☐ High cholesterol	☐ Thyroid disorder	☐ Gonorrhea	☐ Polio
☐ Asthma	☐ Emphysema	☐ Measles	☐ Hepatitis
☐ Jaundice	☐ Bleeding tendency	☐ HIV	☐ Migraines
☐ Syphilis	☐ Nervous disorder	☐ High fever	☐ Other heart illnesses
☐ Meningitis	☐ Mononucleosis	☐ Cancer	☐ Shingles
☐ Epilepsy	☐ Multiple Sclerosis	☐ Other liver illnesses	☐ Other:_____
☐ Paralysis	☐ High blood pressure	☐ Glaucoma	
☐ Other lung illnesses	☐ Other kidney illnesses	☐ Vein condition	
☐ Sleep Apnea	☐ Allergies	☐ Tuberculosis	

Immunizations & dates:_____
Surgeries & dates :_____
Other Serious injuries or accidents:_____

Patient Profile:

Medications

Please list all prescriptions, over the counter medications, vitamins and supplements which you use OR please provide me with a separate list.



Please mark any areas of pain (with) xxxxx's), scars (with ------) and numbness (with OOOO's).

Currently what is your pain scale:
Least 1 2 3 4 5 6 7 9 10 + _____

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:_____

Is there a time of day when the symptom feels better?
When_____ Worse? _____

What are your health & treatments goals?

Have you ever had acupuncture? Yes_____ No_____ Last treatment date:_____
Have you ever taken herbal medicine? Yes_____ No_____
Do you have any medical experiences that I should be aware of:_____

Patient Signature:_____

Cancellation Policy: In order to provide you with the best care, please arrive 10 minutes prior to your appointment. We require 24 hours' notice of cancellation or you will be charged a $85 fee. Please remember that failure to appear for your appointment prevents others from receiving care. Privacy policy attached document.

I have received a copy of Bridget Puchalsky L.Ac. HIPAA Privacy Policies. Initials:_____

I have read the above statement about missed appointments. Initials_____

Please check the following that currently pertain to you. We will discuss together during your intake in more detail so if there are any unclear items put "?".

Overall Energy Levels

☐ Low energy AM_____ PM_____
☐ General weakness
☐ Easily catch colds
☐ Difficulty daytime energy
☐ Feel worse after exercise
☐ Overall achy feeling in the body
Libido level is: ☐ Excessive ☐ Low
☐ Average

☐ How many colds this year _____?
☐ General sensation of body heaviness
☐ Mental heaviness
☐ Mental fogginess
☐ Dizziness
☐ Swollen joints (where? _____)
☐ Edema (where?_____)

Overall Temperature

COLD

☐ Cold body temperature
☐ More sensitive to cold than average
☐ Hot flashes any time of the day or night
☐ Hot body temperature (sensation)
☐ Alternating fevers and chills
☐ Rarely Perspire... ☐ even when exercising
☐ Take water to bed
☐ Excessive Thirst

HOT

☐ Heat in the hands, feet, and chest
☐ Easily Perspire
☐ Afternoon flushes
☐ Graying Hair
☐ Night sweats
☐ Skin dry? _____ Skin moist? _____

Eyes, Ears, Nose, Throat

☐ Headaches ☐ Migraines
Frequency_____
☐ Seasonal Allergies
☐ Continuous Allergies (dust, etc)
☐ Sinus congestion
☐ Nasal discharge ☐ Sneezing
Dry: ☐ lips ☐ mouth ☐ nose ☐ throat
☐ Dizziness
Eyes: ☐ Itchy ☐ Bloodshot ☐ Dry
☐ Watery
☐ Gritty Eyes ☐ See floating black spots
☐ Decreased night vision
☐ Ringing in ears: ☐ High pitch ☐ Low pitch
☐ Low pitched ringing in ears
☐ Ear aches
☐ Mouth sores ☐ Tongue sores ☐ Bad breath
☐ Bleeding, swollen, painful gums
☐ Sore throat ☐ Phlegm in throat
☐ Difficulty Swallowing
☐ Jaw Pain (TMJ)

Heart & Circulation System and Function:

☐ Occasional mental confusion
☐ Chest pain
☐ Chest pain traveling to shoulder
☐ Drink coffee # of cups per week: _____
☐ Difficulty falling asleep
☐ Difficulty keeping asleep
☐ Nightmares
☐ Wake un-refreshed
☐ Anxiety
☐ Restlessness
☐ Palpitations
☐ Chest tightness
☐ Sores on the tip of the tongue
☐ Pain radiating down the arm
☐ Varicose Veins, where?_____
☐ Spider Veins, where?_____

Lung System:

☐ Difficulty breathing ☐ Shortness of breath
☐ Cough ☐ Chest congestion
☐ Asthma: ☐ ongoing ☐ in the past
☐ Smoke cigarettes currently (# of per day: _____); past (# of per day:_____)
☐ Chew tobacco
☐ Sadness ☐ Melancholy ☐ Sleep Apnea
☐ Dry Skin ☐ Cracks in hands or feet

Digestive System:

☐ Low appetite ☐ Excessive appetite
☐ Abrupt appetite
Weight gain ☐ Abrupt weight loss ☐
☐ Fatigue after eating
☐ Hemorrhoids
☐ Over-thinking
☐ Worry
☐ Nose Bleeds
☐ Acid reflux ☐ Heart burn ☐ Mouth sores
☐ Stomach Pain ☐ Nausea
☐ Vomiting
☐ Abdominal bloating
☐ Belching
☐ Passing gas ☐ Hiccoughs
☐ Gurgling noise in the stomach
☐ Ulcer (diagnosed)

☐ Burning sensation after eating
☐ Feel better after eating
☐ Feel better before eating

Large Intestine, Small Intestine function:

☐ Loose stools (frequency___/week)
☐ Constipated (frequency____/week)
☐ Diarrhea (frequency___/week)
☐ Incomplete Bowel Movement (BM)
☐ Alternating diarrhea and constipation
☐ Feel worse before BM
☐ Feel better before BM
☐ Blood in stools (frequency___/month)
☐ Mucous in stools (frequency___/month)
☐ Undigested food in stools (other than corn)
☐ Frequency of BM # per day_____

Liver, Gall Bladder function:

☐ Anger easily ☐ Frustration
☐ Depression ☐ Irritability
☐ Pain in the ribs
☐ Tightness in the chest
☐ Bitter taste in the mouth
☐ Tingling sensation ☐ Numbness
☐ Weak fingernails
Muscle: ☐ spasm ☐ twitching
☐ cramping
☐ Recreational drugs list any:_____
☐ Gall stones (☐ history or ☐ current)
☐ Gallbladder removed Date_____
☐ Seizers
☐ Cold Hands ☐ Cold Feet
☐ Convulsions
☐ Skin rashes, where?____how long?_____
☐ Drink alcohol
☐ Headache at the side(s) of the head
☐ PMS symptoms (more detail below)
☐ Restless Leg Syndrome
☐ Exposure to toxicity

Kidney, Urinary Bladder function:

☐ Kidney stones
☐ Kidney infection date_____
☐ Wake during the night to urinate
☐ Lack of bladder control
☐ Fear
☐ Easily startled
☐ Frequent cavities, other dental problems (past or present)
☐ Easily broken bones
☐ Weakness in low back
☐ Memory problems
☐ Excessive hair loss

Urination:

☐ Dark yellow (often)
☐ Reddish ☐ Blood in Urine
☐ Cloudy
☐ Scanty
☐ Profuse
☐ Interrupted Stream
☐ Weak Stream
☐ Burning ☐ Painful
☐ Difficult ☐ Urgent
☐ Frequent
☐ Strong odor ☐ Discharge
☐ Bladder Infections dates_____
☐ Sexually transmitted disease

Which? _____dates____

Muscle/Skeletal

☐ Neck tension ☐ Pain
☐ Limited Range-of-Motion in neck
☐ Shoulder tension ☐ Pain
☐ Limited Range-of-Motion in shoulder
☐ Upper back tension ☐ Pain
☐ Muscle weakness, where_____
☐ Loss of muscle function or paralysis, where:_____
☐ Painful knees ☐ Weak knees
☐ Low back pain
☐ Hip pain ☐ Pain radiating down leg
☐ Pain in Hands ☐ Pain in Feet

Women only:

☐ Regular monthly menstrual cycle
Age of first menstruation:_____
Average number of days of flow:_____
☐ Severe Menstrual cramps
☐ Mild Menstrual cramps
# of children:_____ # of live births:_____# of pregnancies:_____
Dates of pregnancies:_____

Pregnant Currently? ☐ Yes ☐ No
☐ Possible
Age of menopause (if applicable):_____
Average number of days of entire cycle: _____to _____
☐ Bleeding between periods
☐ Unusual vaginal discharges (please describe)
Color_____ Smell_____

Date of Last Pap smear_____Results_____
Date of Last Mammography_____Results_____

Do you experience any of the following pre-menstrual syndromes (PMS)?
How many days before period does the PMS usually start? _____days.

☐ nausea
☐ food cravings
☐ depression
☐ vomiting
☐ headaches
☐ irritability
☐ water retention
☐ migraines
☐ anxiety
☐ pain, where?_____
☐ breast swelling
☐ breast tenderness
☐ other emot

Do you currently experience any of the following menopausal symptoms?

☐ hot flashes
☐ excessive sweating Day_____Night_____
☐ vaginal dryness
☐ discomfort during intercourse
☐ difficultly getting sound sleep
☐ mood changes ☐ physical change

Men only:

☐ Swollen testes ☐ Testicular pain ☐ Impotence ☐ Premature ejaculation
☐ Feeling of coldness or numbness in external genitalia
☐ Erectile Dysfunction (ED) ☐ Vasectomy in Year_____
☐ Unusual discharges from the penis ☐ Herpes Type I ☐ Herpes Type II
☐ Other_____

Life Style Choices:

☐ Drink caffeinated beverages, # _____ day, week or month (please circle one)

Type (circle): coffee, tea, soda, chocolate, energy drinks

Exercise: ☐ mild ☐ moderate ☐ vigorous # of days / week_____

Total # of hours/day of "screen" time_____

Diet: ☐ vegetarian, ☐ vegan, ☐ lactose intolerant, ☐ gluten intolerant

☐ Drink alcoholic beverages, # _____per day, week, or month (please circle one)

Other foods that are avoided or excluded_____
# of meals eaten per day_____ # of snacks eaten per day_____
Favorite foods:_____
Frequent cravings these foods:_____

Are there any other information about your diet or lifestyle that you'd like to share?