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

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

Patient Profile:

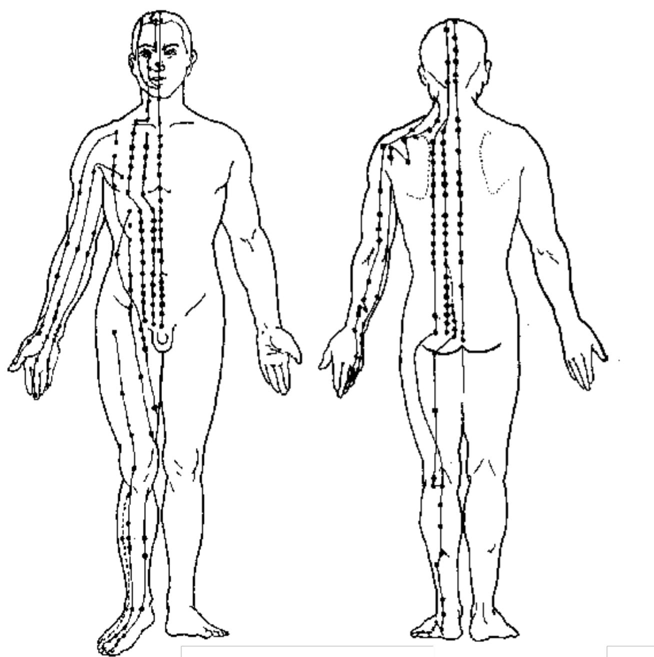
Medications

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?