

SHIVA HEALTH SERVICES

Oriental Medicine Center

Health History Questionnaire Date _____/_____/_____

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 any questions, please ask. Thank you.

Name:		Date of birth:	
Address:	City:	State:	Zip:
Home phone:		Work phone:	
Height:	Weight:	Occupation:	
Family Physician:		Referred by:	
Emergency contact:		Emergency contact phone:	
Relationship status (optional): <input type="checkbox"/> Single <input type="checkbox"/> Married/Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Have you been treated by acupuncture or Traditional Chinese Medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No			

What is/are the main problem(s) you would like us to help you with?: _____

How long ago did this problem begin?: _____

To what extent does this problem interfere with your daily activities? _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried?: _____

Past Medical History: Cancer _____ High Blood Pressure _____ Thyroid Disease _____
(please include date) Diabetes _____ Heart Disease _____ Seizures _____
Hepatitis _____ Rheumatic Fever _____ Venereal Disease _____

Other _____

Surgeries (type of and date): _____

Significant Trauma (auto accidents, falls etc.): _____

Significant Dental Work (type and date): _____

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

Allergies (drugs, chemicals, foods/result): _____

Family Medical History (check): Diabetes High Blood Pressure Stroke Asthma
 Cancer Heart Disease Seizures Allergies
 Other: _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you have a regular exercise program? Yes No Please describe: _____

Have you ever been on a restricted diet? Yes No What kind?: _____

Please Describe Your Average Daily Diet

Morning _____

Afternoon _____

Evening _____

How many packs of cigarettes do you smoke per day? _____ How much coffee, tea or cola do you drink per week? _____

How much alcohol do you drink per week? _____ Please describe any use of drugs for non-medical purposes: _____

Please Check Any Symptoms You Have Had in the Last Three Months

General

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop
- Time of day? _____
- Edema
- Where: _____

Poor sleeping
 Tremors
 Poor balance
 Cravings
 Change in appetite
 Poor appetite
 Weight gain
 Weight loss

Skin and Hair

- Rashes
- Itching
- Change in hair or skin
- Ulcerations
- Eczema
- Oozing on skin lesion

Hives
 Pimples
 Recent moles
 Loss of hair
 Dandruff

Other hair or skin problems: _____

Head, Eyes, Ears, Nose And Throat

- Dizziness
- Migraines
- Headaches
- When: _____
- Where: _____
- Facial pain

- Glasses
- Poor vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye dryness
- Excessive tear
- Discharge from eyes
- Poor hearing
- Ringing in ears
- Earaches
- Discharge from ear

- Nose bleeds
 - Sinus congestion
 - Nasal drainage
 - Grinding teeth
 - Teeth problems
 - Jaw clicks
 - Concussions
 - Recurrent sore throats
 - Hoarseness
 - Sores on lips or tongue
- Other head or neck problems: _____

Cardiovascular

- High blood pressure
 - Low blood pressure
 - Chest discomfort/pain
 - Heart palpitations
 - Cold hands or feet
 - Swelling of hands
 - Swelling of feet
 - Blood clots
 - Fainting
 - Difficulty in breathing
- Other heart or blood vessel problems: _____

Respiratory

- Cough
 - Asthma/wheezing
 - Pain with a deep breath
 - Difficulty in breathing when lying down
 - Production of phlegm. What color: _____
 - Coughing blood
 - Pneumonia
 - Bronchitis
- Other lung problems: _____

Gastrointestinal

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion
- Diarrhea
- Constipation
- Chronic laxative use

- Blood in stools
 - Black stools
 - Abdominal pain or cramps
 - Gas
 - Rectal pain
 - Hemorrhoids
- Other stomach or intestinal problems: _____

Genito-Urinary

- Pain on urination
 - Urgency to urinate
 - Frequent urination
 - Blood in urine
 - Decrease in flow
 - Unable to hold urine
 - Dribbling
 - Kidney stones
 - Impotency
 - Change of sexual drive
 - Sores on genitals
- Do you wake up to urinate?
 Yes No
- How often? _____

Any particular color to your urine?

Other genital or urinary system problems:

Pregnancy And Gynecology

- Number of pregnancies: _____
 Number of births: _____
 Number of premature births: _____
 Number of miscarriages: _____
 Number of abortions: _____
 Age at first menses: _____
 Period between menses (days): _____
 Duration of menses (days): _____
 First date of last menses: _____
- Heavy periods
 - Light periods
 - Painful periods
 - Irregular periods
 - Changes in body/psyche prior to menstruation
 - Clots
 - Menopause:
 Age _____
 Year _____

- Vaginal discharge
 - Postcoital bleeding
 - Vaginal sores
- Date of Last Pap: ____/____/____
- Breast lumps
 - Nipple discharge
- Do you practice birth control?
 Yes No
- What type and for how long?

Musculoskeletal

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pain
- Hip pain
- Knee pain
- Foot/ankle pain
- Muscle pain
- Muscle weakness

Neuropsychological

- Seizures
- Areas of numbness
- Weakness
- Sleep disorder
- Concussion
- Bad temper
- Loss of control/violence potential
- Vertigo
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Substance abuse

Have you ever been treated for emotional problems?
 Yes No

Have you ever considered or attempted suicide?
 Yes No

Other neurological or psychological problems
