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Acupuncture Atlanta

Health Questionnaire

Patient Name

Instructions: Indicate those symptoms that currently apply to you.

PART ONE: Musculoskeletal & Nervous System

Muscles - sore	No symptoms	Scoliosis	No symptoms
Muscles - aching	No symptoms	Headaches	No symptoms
Muscles - weak	No symptoms	Migraine headaches	No symptoms
Muscles - tight	No symptoms	No feeling/numbness/tingling	No symptoms
Muscles - cramps	No symptoms	Paralysis	No symptoms
Muscles - jerking	No symptoms	Convulsions/seizures	No symptoms
Muscles - bursitis	No symptoms	Head injury	No symptoms
Arthritis	No symptoms	Knocked unconscious	No symptoms

Broken bones (list)

Any bone or joint disease (list)

Recurrent dislocations (list)

Other injuries (list)

PART TWO: Digestive system & Abdomen

Poor Appetite	No symptoms	Bloody stool	No symptoms
Excessive appetite	No symptoms	Black stool	No symptoms
Irregular appetite	No symptoms	Fatty stool	No symptoms
Change in appetite	No symptoms	Diarrhea	No symptoms
Change in eating habits	No symptoms	Constipation	No symptoms
Change in nausea	No symptoms	Hemorrhoids	No symptoms
Change in indigestion	No symptoms	Bleeding hemorrhoids	No symptoms
Change in heartburn	No symptoms	Hemorrhoids - Piles	No symptoms
Change in "nervous stomach"	No symptoms	Rectal bleeding	No symptoms
Change in ulcers	No symptoms	Parasites	No symptoms
Change in belching/burping	No symptoms	Worms	No symptoms
Change in gas/flatulence	No symptoms	Hepatitis	No symptoms
Abdominal bloating	No symptoms	Liver problems	No symptoms
Abdominal pain	No symptoms	Gallbladder problems	No symptoms
Vomiting food	No symptoms	Pancreas problems	No symptoms
Vomiting blood	No symptoms	Ulcers	No symptoms
Vomiting bile	No symptoms	Abdominal hernia	No symptoms
		Hiatal hernia	No symptoms
		Inguinal hernia	No symptoms

PART THREE: Heart & Circulation

Chest pain	No symptoms	High blood pressure	No symptoms
Pain over heart	No symptoms	Low blood pressure	No symptoms
Rapid heart beat	No symptoms	Varicose veins	No symptoms
Irregular heart beat	No symptoms	Swelling/edema	No symptoms
Slow heart beat	No symptoms	ankle swelling	No symptoms
Heart palpitations	No symptoms	Hand swelling	No symptoms
		Pain in calf while walking	No symptoms

Other heart problems (describe)

PART FOUR: Skin, Hair & Nails

Itchy skin	No symptoms	Excessive perspiration	No symptoms
Sensitive skin	No symptoms	deficient perspiration	No symptoms
Rash	No symptoms	Premature gray hair	No symptoms
Bruise easily	No symptoms		

Nail problems (describe)

Other hair/scalp problems (describe)

PART FIVE: Reproductive system

Vaginal discharge	No symptoms	Heavy menstrual flow	No symptoms
Abnormal vaginal bleeding	No symptoms	Medium menstrual flow	No symptoms
Vaginal pain	No symptoms	Light menstrual flow	No symptoms
Breast tenderness	No symptoms	Genital lesions	No symptoms
Breast lumps	No symptoms	Hernia	No symptoms
Breast discharge	No symptoms	Testicle pain	No symptoms
Menstrual cramps	No symptoms	Testicle mass or lump	No symptoms
Mood changes, menstrual cycle rel	No symptoms	Prostrate problems	No symptoms
Menopause problems	No symptoms	Prostrate problems	No symptoms
Hot flashes	No symptoms	Erection problems	No symptoms
		Ejaculation problems	No symptoms

Length of menstrual cycle (start to start in days)		Date of last period (1st day of period)	
Number of pregnancies		Number of children	

Birth control method

Sexual difficulties (describe)

PART SIX: Kidney & Bladder

Painful urination	No symptoms	Discolored urine	No symptoms
Frequent urnination	No symptoms	Bloody urine	No symptoms
Difficult urination	No symptoms	Strong odor in urine	No symptoms
Urgent urination	No symptoms	Urinary infection	No symptoms
Hesitation or intermittent urination	No symptoms	Urethral discharge	No symptoms
Urination at night	No symptoms	Loss of bladder control	No symptoms
Excessive urine	No symptoms	Kidney stones	No symptoms
Scanty urine	No symptoms		

Other related problems (describe)

PART SEVEN: Respiratory System

Difficulty breathing	No symptoms	Coughing of blood	No symptoms
Painful breathing	No symptoms	Wheezing or asthma on exertion	No symptoms
Shortness of breath on exertion	No symptoms	Wheezing or asthma at night	No symptoms
Shortness of breath at night	No symptoms	Hyperventilation	No symptoms
Persistent cough	No symptoms	Infrequent sinus congestion	No symptoms
Coughing of phlegm	No symptoms	Chronic sinus congestion	No symptoms

PART EIGHT: Eye, Ear, Nose, Throat & Mouth

Eye Strain	No symptoms	Difficulty breathing through nose at night	No symptoms
Eye inflamation	No symptoms	Difficulty breathing through nose during day	No symptoms
Blurred vision	No symptoms	Sore throat	No symptoms
Ear pain	No symptoms	Hoarseness	No symptoms
Noises or ringing in ears	No symptoms	Difficulty with swallowing	No symptoms
Discharge from ears	No symptoms	Difficulty with speech	No symptoms
Loss of hearing	No symptoms	Difficulty with chewing	No symptoms
Loss of sight	No symptoms	Teeth problems	No symptoms
Loss of taste	No symptoms	Gum problems	No symptoms
Loss of smell	No symptoms	Mouth ulcers	No symptoms
Nose pain	No symptoms	Bad taste in mouth	No symptoms
Nose bleeding	No symptoms	Excessive saliva	No symptoms
Discharge from nose	No symptoms	Deficient saliva	No symptoms

Other vision problems (describe)

Tounge problems (describe)

PART NINE: Miscellaneous

Have you been diagnosed as having cancer	No	Tire easily	No symptoms
Have you been diagnosed as having diabetes	No	General fatique	No symptoms
Have you been diagnosed as having hypoglycemia	No	Difficulty concentrating/trouble thinking	No symptoms
Have you been diagnosed as having a STD	No	Poor memory	No symptoms
Have you been diagnosed as having mononucleosis	No	Dizziness	No symptoms
Have you been diagnosed as having AIDS	No	Fainting	No symptoms
Have you been diagnosed as having CMV	No	Fever	No symptoms
Have you been diagnosed as having Epstein-Barr	No	Chills	No symptoms
Thyroid problems (hypo)	No symptoms	Night sweats	No symptoms
Thyroid problems (hyper)	No symptoms	Shaky feeling	No symptoms
Rapid weight gain	No symptoms	Confusion	No symptoms
Rapid weight loss	No symptoms	Irritable	No symptoms
Heat and cold intolerance	No symptoms	Depression	No symptoms
Cold hands and feet	No symptoms	Anxiety	No symptoms
Excessive thirst	No symptoms	Emotional crisis/breakdown	No symptoms
Slow to heal	No symptoms	Cry easily	No symptoms
Enlarged glands	No symptoms	Anemia	No symptoms
Water retention	No symptoms	Dehydration	No symptoms

Favorite foods (list)

Allergies: food and other (list)

Significant medical history (illnesses, surgeries, injuries) birth to present not included on this questionnaire

Weight now		Max weight	
Weight one year ago		Date of max weight	

Surgery - appendix	No	Surgery - ovary or ovaries	No
Surgery - gallbladder	No	Surgery - uterus	No

Other surgeries (describe)

Have you ever had a transfusion?	No
Blood transfusion?	No
Plasma transfusion?	No
Year of transfusion	

Have you ever had x-rays of your back?	No	Have you ever had x-rays of your gallbladder?	No
Have you ever had x-rays of your neck?	No	Have you ever had x-rays of your stomach?	No
Have you ever had x-rays of your extremities?	No	Have you ever had x-rays of your colon?	No
Have you ever had x-rays of your chest?	No		

Other x-rays (describe)

Have you ever had a CT scan?	No	Have you ever had a MRI?	No

PART TEN: Personal Habits

Do you sleep well?	No	Do you take vacations?	No
Awaken rested?	No	Weeks of vacation per year	
Average hours of sleep per night		Have you been treated for alcoholism?	No
Do you have regular bowel movements	No	Have you been treated for drug abuse?	No
Sex entirely satisfactorily	No	Do you participate in sports or have hobbies for at least 3hrs/wk?	No
Do you like your work?	No	Do you exercise?	No
Do you watch television?	No		
Reading (hours per day)			

Describe your exercise

What types of stress are you under?

What do you do to relieve stress?

Do you use vitamins?	Never	Do you use recreational drugs?	Never
Do you use laxatives?	Never	Coffee/tea (cups per day)	
Do you use sedatives/tranquilizers?	Never	Do you use soft drinks?	Never
Do you use sleeping pills, etc?	Never	Cigarettes (packs per day)	
Do you use aspirins, etc?	Never	Do you use cigars or pipe?	Never
Do you use appetite suppressants?	Never	Do you use chewing tobacco or snuff?	Never
Do you use alcoholic beverages?	Never	Do you use marijuana?	Never

Briefly describe other significant health problems and concerns not listed on this questionnaire

PART ELEVEN: Family History

For your mother, father, sisters, brothers, children, and spouse, check applicable illnesses and describe.

Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
	What kind of cancer?					
Tuberculosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Heart trouble	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
High blood pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Epilepsy	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Emotional crisis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Asthma, hives, hayfever	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Other	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
Death	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Children	☐ Spouse
	Cause & year	Cause & year	Cause & year	Cause & year	Cause & year	Cause & year