Sound Acupuncture PLLC

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Health History Questionnaire

Date: __/__/__

Patient's Name (Last, First, M.I.)	**DOB (mm/dd/yyyy)**	**Sex (M/F)**	**Patient Status: Single ☐ Married ☐ Other ☐** **Employed Student: F-Time P-Time**	
Patient's Address (No. Street)			**Patient's Occupation**	
City	**State**	**Zip**	**Phone (10 digit)**	
Email Address	**Primary Physician**		**Emergency Contact Name and #**	
Insured's Name (Last, First, MI) if different from above:	**DOB (mm/dd/yyyy)**	**Sex (M/F)**	**Insurance ID #:**	
Insured's Address (No. Street) if different from above:	**Phone # (10 digit):**		**Employer:**	
City	**State**	**Zip**	**PIP/Auto Claim #:**	**Group ID #:**
Insurance Company	**Plan Name or Program**			
Billing Address:	**Telephone or Adjustor's Contact Info:**			
Onset/Injury Date:	**Similar Condition (Y/N)**	**Work Related (Y/N)**	**Auto Accident (Y/N) U.S. State**	**Other Acc. (Y/N)**

What is your main complaint today?_____

When did this problem begin? (Please be specific)_____

What do you think caused it? Is the cause still present?_____

What treatments have you tried already? What were the results?_____

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

How severe is your problem right now? (Please mark the scale below)

No problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem Moderate Worst Imaginable

Patient Name: _____ Date: _____

Past Medical History (please indicate by date(s):

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Asthma _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____

Other: _____

Surgeries (type and date): _____

_____

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

_____

Significant Dental Work (type and date): _____

_____

Family Medical History

☐ High Blood Pressure	☐ Alcoholism	☐ Cancer:	☐ Allergies:
☐ Heart Disease	☐ Seizures	_____	_____
☐ Arteriosclerosis	☐ Asthma	_____	_____
☐ Stroke	☐ Diabetes	_____	_____

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

_____

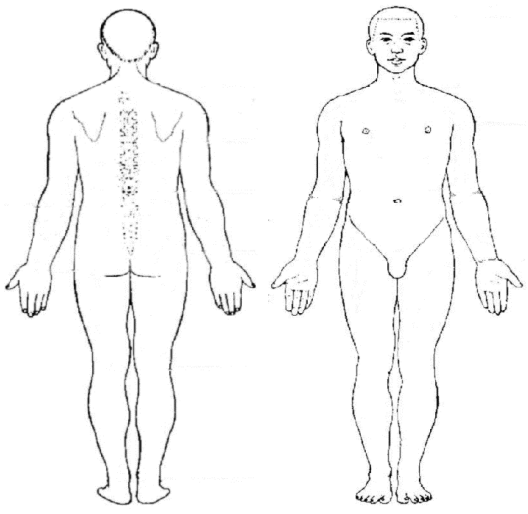
Do you exercise regularly? Y or N Please describe: _____

_____

Comments (please list any other problems you would like to discuss): _____

_____

Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- ☐ Temporary relief of symptoms/pain control
- ☐ Eliminate root or cause of problem (if possible)
- ☐ Lessen/eliminate habits which caused the condition or made it worse
- ☐ Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of symptoms you have had in the past 2 weeks.

Patient Name: _____ Date: _____

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold/ 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 change

Gain / Loss _____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches

Where: _____

- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ 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/tongue

*Other head / 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/blood vessel problems:*_____

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm: *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
- ☐ 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
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?

☐ Yes ☐ No

How often? _____

What color is your urine?

_____

*Other genital or urinary system problems?*_____

Pregnancy and Gynecology

of pregnancies:_____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions:_____
Age at first menses:_____
Length of full cycle:_____
Length of menses:_ _____
Last menses start date: _____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:

Age: _____
*Year:*_____

- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?

☐ Yes ☐ No

What type and for how long?
pain/cramps
_____

Musculoskeletal

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

*Other pain?*_____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?

☐ Yes ☐ No

Patient Name: _____ Date: _____

Last Physical Date: _____ Doctor: _____ Results: _____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	
Coffee:	☐	☐	☐	☐	
Tea:	☐	☐	☐	☐	
Tobacco:	☐	☐	☐	☐	
Exercise:	☐	☐	☐	☐	
Sleep:	☐	☐	☐	☐	
Appetite:	☐	☐	☐	☐	
Energy Level:	☐	☐	☐	☐	
Medication:	☐	☐	☐	☐	
Vitamins:	☐	☐	☐	☐	
Food Intake:	☐	☐	☐	☐	
Teeth problems:	☐	☐	☐	☐	
Drugs:	☐	☐	☐	☐	
Salt Intake:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	
Stress Level:	☐	☐	☐	☐	

Diet Please give a general description of the food you eat during a "typical" day.

Morning: .....

Afternoon: .....

Evening: .....

Before bed: .....

Between meals: .....

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

What medicines have you taken within the last 2 months? (prescriptions, vitamins, over-the-counter drugs, herbs)

What allergies do you have? What reactions do you have to these chemicals, foods, etc?