( ) Ellijay
9 Russel Drive, #150
Ellijay, GA 30540

Acupuncture in North Georgia
Health History Questionnaire

( ) Blairsville
1650 Tate Road
Blairsville, GA 30512

Use the back of last page to answer anything that doesn't fit

Patient Information

Name_____Date_____
Address _____[_____
City _____ State _____ Zip_____
Home Phone_____Cell Phone _____Email:_____
Height _____ Weight _____ Sex: _ Male _ Female Marital Status _____
Date of Birth_____Age_____
Occupation_____Employer_____
Have you had acupuncture before? _ No _ Yes, Name of Acupuncturist _____

Major Complaint

Primary reason for your visit today? _____

_____

Has this condition been diagnosed by a physician, or other provider?
_ No _ Yes, Diagnoses _____
Are you being treated for this condition by anyone else? _ Yes - No
If yes, what is the treatment?_____
Have these treatments helped? _ Yes _ Somewhat _ Not Much _ Not at All
How does this condition affect you? _____
How long have you had this condition?_____

Personal Health History

Your general health as a child was? _ Excellent _ Good _ Average _ Poor
Did you feel safe and nurtured as a child? _ Always _ Usually _ Sometimes _ Never

Check all the illnesses or conditions which <u>you</u> currently have or have had in the past:

_ AIDs / HIV	_ Eating Disorders	_ Kidney Disease	_ Rheumatic Fever
_ Alcoholism	_ Epilepsy	_ Measles	_ Scarlet Fever
_ Allergies	_ Glaucoma	_ Meningitis	_ Sexually Transmitted
_ Antibiotic Use	_ Heart Disease	_ Mental Illness	Disease
_ Asthma	_ Hepatitis	_ Multiple Sclerosis	_ Stroke
_ Bleed Easily	_ High Blood Pressure	_ Mumps	_ Tuberculosis
_ Cancer	_ High Fevers	_ Obesity	_ Typhoid Fever
_ Chicken Pox	_ Hyperthyroid	_ Pneumonia	_ Ulcers
_ Diabetes	_ Hypothyroid	_ Polio	_ Vascular Disease
_ Drug Abuse	_ Jaundice	_ Other _____	

Are you taking Coumadin or Warfarin? _ Yes __ No
Do you have a pacemaker? _ Yes __ No Do you have seizures? _ Yes __ No
Do you currently have any infectious diseases? _ Yes __ No _ Possibly
If yes, please identify: _ HIV / AIDs _ Hepatitis B _ Hepatitis C _ Flu / Cold _ Streptococcus
_ Mononucleosis _ Tuberculosis _ Other _____
Known or suspected allergies:_____

Personal Health Inventory

Please put a check mark (X) by the symptoms that you have now.
Place a star (*) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang
_ anxiety
_ catches colds easily or frequently
_ chest pain traveling to shoulder
_ cold feet
_ cold hands
_ difficult to concentrate
_ dizziness
_ dream disturbed sleep
_ dry skin
_ fatigue
_ feverish in the afternoon or flushes
_ general weakness
_ heat sensations in hands, feet, chest
_ insomnia
_ mental confusion
_ night sweats
_ palpitations
_ restlessness
_ sores on tip of tongue
_ speech problems
_ sweats easily
_ thirst, at night
_ you feel worse after exercise
_ you see floating black spots

IX
_ allergies
_ chills alternating with fever
_ cough
_ difficulty breathing
_ dry mouth, throat, nose
_ feeling achy
_ headaches
_ nasal discharge
_ nose bleeds
_ shortness of breath
_ sinus congestion
_ sneezing
_ sore throat
_ stiff neck/ shoulders

XII
_ abdominal bloating and / or gas after eating
_ belching
_ chest congestion
_ constipation
_ diarrhea
_ eating disorders
_ fatigue after eating
__ gas
_ general feeling of heaviness in your body
_ hemorrhoids
_ loose stools
_ low appetite
_ mental heaviness, sluggishness or fogginess
_ nausea
_ prolapsed organs (previously diagnosed)
_ swollen feet
_ swollen hands
_ you bruise easily

XI
_ bad breath
_ belching
_ bleeding, swollen or painful gums
_ burning sensation after eating
_ constipation
_ heartburn
_ large appetite
_ mouth sores (Canker or cold sores)
_ stomach pain
_ vomiting

I / VI
_ chest pain
_ edema
_ high blood pressure
_ insomnia
_ low blood pressure
_ palpitations
_ stroke
_ varicose veins

VIII / VII
_ bitter taste in mouth
_ blood shot eyes
_ blurred vision
_ chest pain
_ convulsions
_ diarrhea alternating with constipation
_ difficulty swallowing
_ dry eyes
_ feeling of a lump in your throat
_ headache at the top of your head
_ hot flashes
_ muscle spasms, twitching, cramping
_ numbness of hands and feet
_ pain in rib cage
_ red, sore or irritated eyes
_ seizures
_ skin rashes
_ tight feeling in chest
_ TMJ or locked jaw
_ you anger easily
_ you feel better after exercise

IV / III
_ frequent urination
_ hair loss
_ joint pain
_ lack of bladder control
_ loose teeth
_ low back pain
_ memory problems
_ night blindness or low vision
_ ringing in your ears
_ sore, cold or weak knees
_ you get up more than one time at night to urinate

Other _____
_____
_____
_____
_____
_____

Family History

How do you feel about the following areas of your life in the past month.

Significant Other _ Great _ Good _ Fair _ Poor _ N/A Comments _____

Family _ Great _ Good _ Fair _ Poor _ N/A Comments _____

Self _ Great _ Good _ Fair _ Poor Comments _____

Check illnesses which have occurred in any of your <u>blood relatives</u>:

_ Alcoholism _ Cancer _ Heart Disease _ Mental Illness

_ Allergies _ Diabetes _ High Blood Pressure _ Obesity

_ Bleed Easily _ Epilepsy _ Kidney Disease _ Stroke

_ Other _____

Women Only

Are you pregnant? _ Yes, how many months?_____ _ No _ Trying _ Maybe

Method of birth control?_____

Age of First Menses_____ Date of Last Menses_____ Age of Menopause _____

Typical Length of Menses (Days You Bleed) _____

Typical Length of Cycle (From the 1st Day of One Cycle to 1st Day of the Next)_____

Number of: Pregnancies_____ Births_____ Abortions_____ Miscarriages _____

Hysterectomy _ Yes _ Partial _ Complete Date _____ _ No

Check all that apply to you:

_ Scanty Flow _ Painful Periods _ Low Libido

_ Heavy Flow _ Breast Tenderness _ Excessive Libido

_ Clotting _ Breast Lumps _ Painful Intercourse

_ Vaginal Discharge _ Nipple Discharge _ Infertility

_ Abnormal Pap Smear _ Fibrocystic Breasts _ Fibroids

_ Menopausal Symptoms _ Bleeding Between Cycles _ Endometriosis

_ Premenstrual Problems _ Irregular Cycles _ Ovarian Cysts

_ Breast implants

_ Other _____

Men Only

Check all that apply to you:

_ Low Libido _ Seminal Emissions _ Prostate Problems

_ Excessive Libido _ Premature Ejaculation _ Testicular Pain

_ Impotence _ Painful Intercourse _ Testicular Redness

_ Vasectomy, Date_____ _ Testicular Swelling

_ Other _____

Medications, please list medications, herbal supplements and vitamins you are currently taking:

Drug / Supplement / Vitamin	Reason for Taking	for How Long	Dosage	Frequency

Lifestyle

How would you rate the following areas of your health in the past month.

Digestion _ Great _ Good _ Fair _ Poor Comments _____

Stools _ Great _ Good _ Fair _ Poor Comments _____
How many times per day?_____Do they feel complete? _ Yes _ No
Stool consistency? _ Loose _ Formed _ Hard to Pass _ Other _____
What is the color of your stools?_____
Is there blood in your stools? _ Yes _ No How Often? _____

Urination _ Great _ Good _ Fair _ Poor Comments_____
How many times per day?_____What color is your urine? _____
After you've gone to sleep do you get up to urinate? _ Yes _ No How Often?_____
Is your urination painful? _ Yes _ No

Appetite _ Great _ Good _ Fair _ Poor Comments _____

Diet _ Great _ Good _ Fair _ Poor Comments

Are you vegetarian or vegan? _ Yes _ No For how long?_____
Please use the back to write a typical day's food intake

Foods You Crave_____When?_____

Daily Water Intake_____Daily Soda Intake_Caffeine? _ Yes _ NoDaily

Coffee Intake Caffeine? _ Yes _ No Daily Tea Intake_Caffeine? _ Yes _ No

Do you drink alcohol? How Much?_____ How Often?_____What kinds? _____
Past Use? _ Yes _ No Date Stopped _____

Do you use tobacco? _ Yes _ No Past Use? _ Yes _ No Date Stopped _____

Do you use recreational drugs? _ Yes _ No Past Use? _ Yes _ No Date Stopped _____

How do you feel about the following areas of your life in the past month?

Energy _ Great _ Good _ Fair _ Poor Comments_____
On a scale of 1 to 10? (10 is high energy)_____

Sleep _ Great _ Good _ Fair _ Poor Comments_____
Hours per night?_____Do you wake feeling rested? _ Yes _ No

Sex Life _ Great _ Good _ Fair _ Poor Comments_____

Work _ Great _ Good _ Fair _ Poor Comments_____

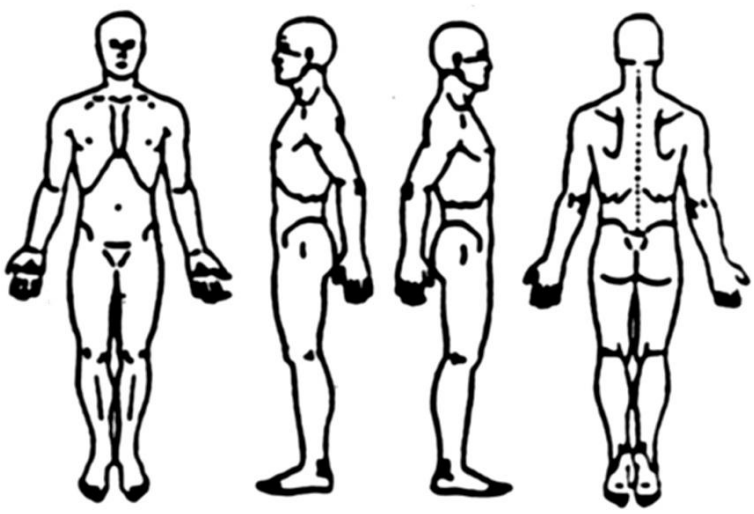
Exercise _ Great _ Good _ Fair _ Poor Comments_____
How often?_____What kind? _____

How would you rate your stress level on a scale of 1 to 10? (10 is high stress) _____

How well do you feel you handle your stress? _ Great _ Good _ Fair _ Poor

Pain

Please answer the following questions if you have pain.



Indicate on the diagram your areas of pain

How long have you had this pain? _____

Describe the onset of your pain?

On a scale of 1-10 (10 being worst) how strong is your pain?_____

What does your pain feel like? (Check all that apply)

_ Dull _ Sharp _ Stabbing _ Sore _ Achy _ Cramping _ Burning _ Constant
_ Comes and Goes _ Fixed _ Moves About

Does the pain radiate? _ No _ Yes Where?_____

What helps the pain? _ Ice _ Heat _ Rest _ Movement _ Pressure _ Moisture
_ Massage _ Nothing _ Other _____

What aggravates the pain? _ Ice _ Heat _ Rest _ Movement _ Pressure _ Moisture
_ Massage _ Nothing _ Other _____

Does anything relieve this pain? (i.e., medications, over the counter drugs, liniments)

Other treatments you have had for this pain? _____

Anything you wish to add? _____

COVID-19 AND/OR DELTA VARIANT: Have you had this? __Yes __No, if so, when_____
Have you had the vaccination? __Yes, __No, if not why? _____
If yes, when? _____

Who may we thank for referring you? _____

The above information is true to the best of my knowledge.

X Patient's Signature_____Date _____