Harmony Acupuncture
Health History Questionnaire

BASIC INFORMATION

Name:		Social Security Number:	
Street:			City:
State:	Zip:	Email:	
Home Phone:		Work:	Cell:
Birth Date:		Height:	Weight:
Occupation:			Marital Status:
Emergency Contact:			Number:

REASON FOR COMING TODAY:

Issue:
How much does this issue affect your daily life?
When did the symptoms begin?
Has a physician given you a diagnosis for this issue?
If so, what is it?
What kind of treatment or therapy have you tried?
Are there any other issues you would like to address?

How did you find out about Harmony Acupuncture? _____

MEDICAL HISTORY

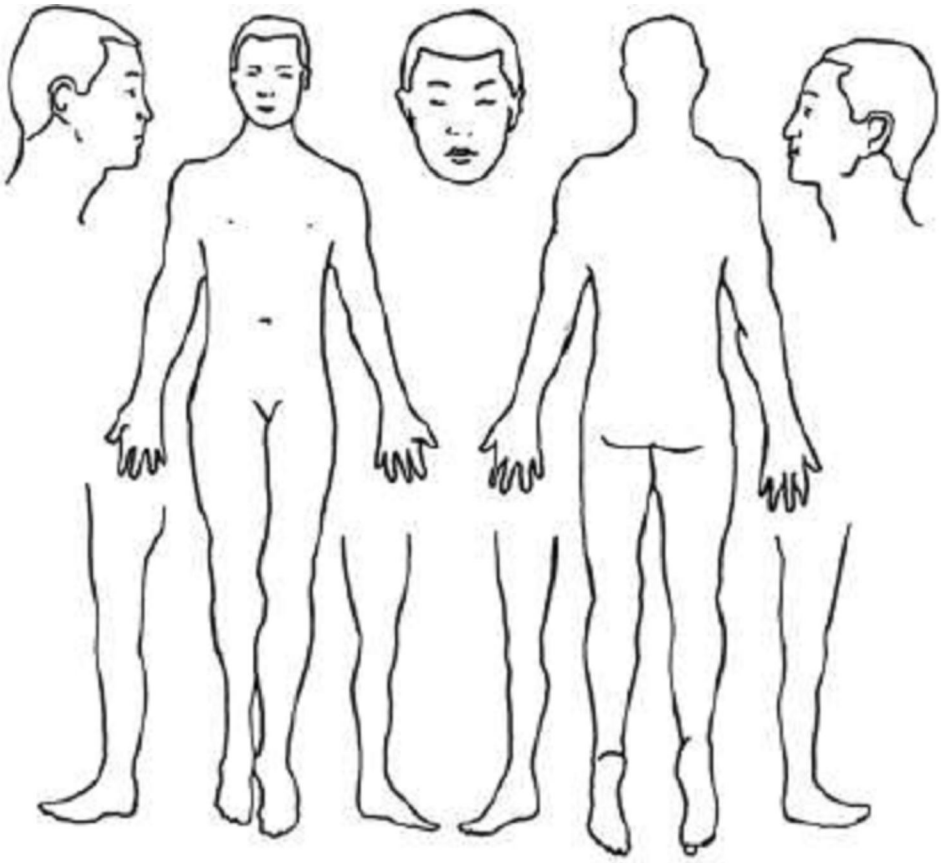
Please Check any that apply	You	Mother	Father	Siblings
Allergies				
Cancer				
Diabetes				
High Blood Pressure				
Heart Disease				
Stroke				
Substance Abuse				
Other:_____				

Have you had any of the following? If so, please describe:
Birth Trauma
Accidents
Surgeries

LIFESTYLE

How does your occupation affect your daily life?		
Please describe the stresses in your life:		
Please describe your average diet:		
How often and how much do you:		
Smoke cigarettes	Drink caffeine	Drink alcohol
Please describe your exercise routine:		
List medications, vitamins, and herbs taken in the last two months:		
Have you taken any drugs for non medical purposes?		

Please mark areas of pain, numbness, or discomfort below:



NAME:

Please check any symptoms you have experienced in the last three months.

GENERAL		
❒ Poor appetite	❒ Night sweats	❒ Localized weakness
❒ Cravings	❒ Fever	❒ Tremors
❒ Changes in appetite	❒ Chills	❒ Bleeding or bruising easily
❒ Change in weight	❒ Fatigue	❒ Poor balance
❒ Strong thirst	❒ Insomnia	❒ Sudden energy drop
❒ Sweat easily	❒ Disturbed sleep	Time of day_____

SKIN AND HAIR		
❒ Rashes	❒ Eczema	❒ New moles
❒ Ulcerations	❒ Acne	❒ Changes in texture
❒ Hives	❒ Dandruff	❒ Other:_____
❒ Itching	❒ Hair loss	_____

HEAD, EYES, EARS, NOSE, THROAT		
❒ Dizziness	❒ Color Blindness	❒ Stuffed nose
❒ Concussions	❒ Night Blindness	❒ Runny nose
❒ Headaches	❒ Cataracts	❒ Nose bleeds
❒ Migraines	❒ Blurry vision	❒ Sores on lips or tongue
❒ Facial pain	❒ Eye Strain	❒ Recurrent sore throat
❒ Glasses/poor vision	❒ Ringing in ears	❒ Teeth problems
❒ Spots in front of eyes	❒ Earaches	❒ Jaw clicks
❒ Eye pain	❒ Poor hearing	❒ Grinding teeth
❒ Sinus pressure	❒ Other	

CARDIOVASCULAR		
❒ Dizziness	❒ Cold hands or feet	❒ Blood clots
❒ Low blood pressure	❒ Swelling hands or feet	❒ Changes in texture
❒ High blood pressure	❒ Chest pain	❒ Other:_____
❒ Fainting	❒ Irregular heartbeat	_____

RESPIRATORY		
❒ Cough	❒ Difficulty breathing	❒ Pneumonia
❒ Coughing up blood	❒ Pain with deep inhalation	❒ Bronchitis
❒ Asthma	❒Other:_____	

GASTROINTESTINAL		
❒ Nausea	❒ Chronic laxative use	❒ Indigestion
❒ Vomiting	❒ Black stools	❒ Belching
❒ Diarrhea	❒ Blood in stools	❒ Gas
❒ Constipation	❒ Rectal pain	❒ Bad breath
❒ Abdominal pain or cramps	❒ Hemorrhoids	❒ Other

GENITOURINARY		
❒ Frequent urination	❒ Pain upon urination	❒ Kidney stones
❒ Urgency to urinate	❒ Blood in urine	❒ Impotence
❒ Unable to hold urine	❒ Decrease in flow	❒ Sores on genitals
❒ Wake at night to urinate?_____ How often? _____		❒ Other

MUSCULOSKELETAL		
❒ Neck pain	❒ Foot/ankle pain	❒ Hip pain
❒ Back pain	❒ Hand/wrist pain	❒ Muscle pain
❒ Knee pain	❒ Shoulder pain	❒ Arthritis
❒ Muscle weakness	❒ Other	

NEUROPSYCHOLOGICAL		
❒ Seizures	❒ Poor memory	❒ Bad temper
❒ Dizziness	❒ Lack of coordination	❒ Easily susceptible to stress
❒ Loss of balance	❒ Depression	❒ Other
❒ Areas of numbness	❒ Anxiety	
Have you ever been treated for emotional problems?		
Have you ever considered or attempted suicide?		

WOMEN ONLY:

REPRODUCTIVE AND GYNECOLOGIC		
❒ Premenstrual changes	❒ Heavy menstrual flow	❒ Premature births
❒ Menstrual clots	❒ Light menstrual flow	❒ Miscarriages
❒ Painful menses	❒ Irregular menses	❒ Abortions
Age at first menses	Age at menopause	Number of pregnancies
Length of cycle	Duration of bleeding	First day last menses
Do you use birth control?		
Are you pregnant? Y ❒ N❒	Is there a possibility you could be? Y❒ N❒	