

() Ellijay
11 Kiker Street
Ellijay, GA 30540

Acupuncture in North Georgia Health History Questionnaire

() Blairsville
563 Gainesville Hwy
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 you 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 blood relatives:

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 No Daily

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 _____

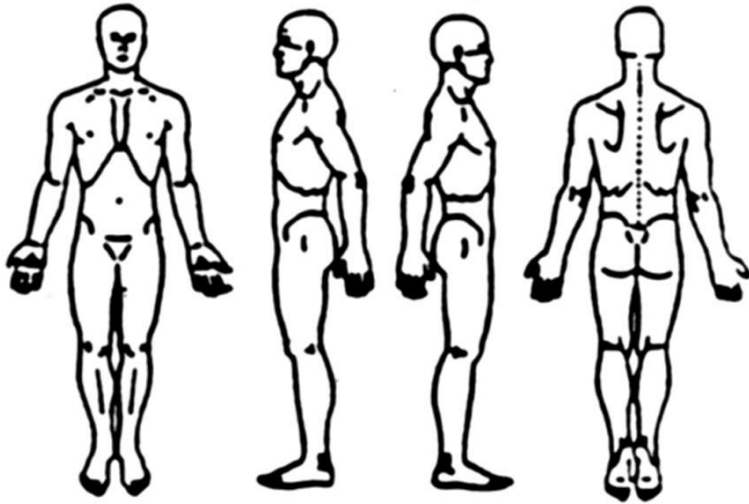
How often? _____ What kind? _____

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 _____