NALU HEALING ARTS

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. ***All of your answers will be held absolutely confidential***. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. Thank you.

Name____**Today's Date** __________________

Street______________________________**City**___________________**State/Zip**________________

Cell Phone__________________________ **eMail** _______________________________________

Appointment reminders by: ____ **E-Mail** ____ **Text / Carrier:** __________________________

Age_____**Date of Birth**_________**Male** _____ **Female**_____ **Height**_______ **Weight**___________

Marital Status: ▫ Married ▫ Never Married ▫ Widowed ▫ Divorced or Separated

Occupation: ____

Referred by: ____

Emergency Contact: ____________________ **Emergency Contact Relation to you:**_____________

Emergency Contact telephone: ____

Have you ever had Epstein-Barr Virus, Strep Throat, or Mono? ▫ Yes ▫ No

Have you ever been treated by acupuncture or Oriental medicine before? ▫ Yes ▫ No

Main Problem you would like us to help you with:____________________________________

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____

How long ago did this problem begin? Please be specific: ______________________________

____

____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

____

____

What other kinds of treatment have you tried? ▫ Western Medicine ▫ Acupuncture
▫ Herbs ▫ Massage ▫ Physical Therapy ▫ Chiropractor ▫ Reiki ▫ Homeopathy
▫ Other:____

Secondary Complaints you would like us to help you with:_______________________________
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Past Personal Medical History of Significant Illnesses: ▫ Asthma ▫ Allergies ▫ Diabetes

▫ Cancer ▫ Stroke ▫ Heart disease ▫ High Blood Pressure ▫ Seizures ▫ Hepatitis

▫ Rheumatic Fever ▫ Thyroid disease ▫ Venereal disease Other:________________________
____
____

Hospitalizations/Surgeries (including dates):____
____
____
____

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

Allergies (drugs, chemicals, metals, foods):____
____

Family Medical History: (check all that are applicable) ▫ Asthma ▫ Allergies ▫ Diabetes

▫ Cancer ▫ Stroke ▫ Heart disease ▫ High Blood Pressure ▫ Seizures ▫ Thyroid

▫ Hepatitis ▫ Rheumatic Fever ▫ Thyroid disease ▫ Venereal disease Other:___________
____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.):__________________
____
____

Are there any areas of your life that you find stressful? Please describe:____________________
____

Do you have a regular exercise program? ▫ No ▫ Yes If yes, please describe:_______________
____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?
▫ No ▫ Yes If Yes, what type of diet? ____

Describe your *average* daily diet:
Morning**:** ____
Afternoon: ____
Evening**:** ____

Do you smoke? ▫ No ▫ Yes If Yes, how many cigarettes or cigars per day? ___________

How many cups of caffeinated coffee, tea, or cola do you drink per week?________________

How many 8 oz. glasses of water do you drink per day?________________________________

How many alcoholic beverages do you drink per week?________________________________

Please describe any use of drugs for non-medical purposes:____________________________

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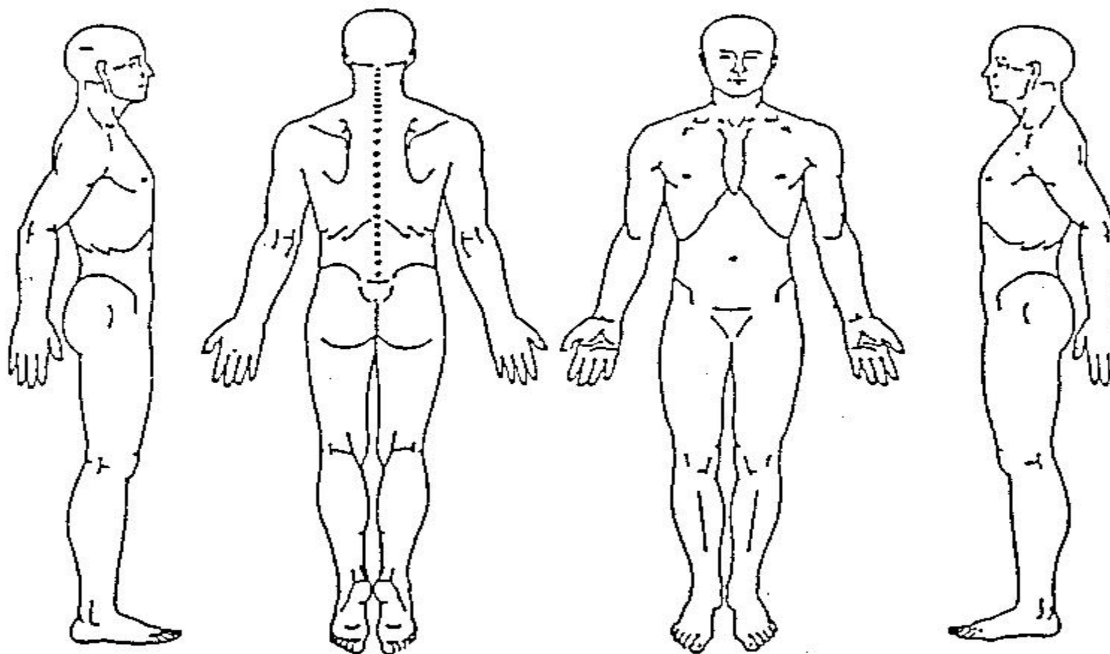
____

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

GENERAL:

- ▫ Fevers ▫ Chills ▫ Fatigue ▫ Sweat easily
- ▫ Poor sleeping ▫ Night sweats ▫ Weight loss ▫ Cravings
- ▫ Weight gain ▫ Change in appetite ▫ Strong thirst for: ▫ Hot drinks ▫ Cold drinks
- ▫ Sudden energy drop, if so what time of day?______________________________
- ▫ Bleed or bruise easily ▫ Peculiar tastes or smells

SKIN & HAIR:

- ▫ Rashes ▫ Ulcerations ▫ Hives ▫ Itching
- ▫ Eczema ▫ Pimples ▫ Dandruff ▫ Loss of hair
- ▫ Recent moles ▫ Psoriasis ▫ Dermatitis ▫ Acne
- ▫ Change in hair or skin texture
- ▫ Any other skin or hair problems?____

HEAD, EYES, EARS, NOSE & THROAT:

- ▫ Dizziness ▫ Concussions ▫ Migraines ▫ Glasses
- ▫ Eye strain ▫ Eye pain ▫ Poor vision ▫ Night blindness
- ▫ Color blindness ▫ Cataracts ▫ Blurry vision ▫ Earaches

□ Ringing in ears □ Spots in front of eyes □ Poor hearing □ Sinus problems
□ Nose bleeds □ Recurrent sore throats □ Grinding teeth □ Clenching jaw
□ Facial pain □ Sores on lips or tongue □ Teeth problems □ Jaw clicks
□ Headaches, where and when?____
□ Any other head or neck problems?____

CARDIOVASCULAR:
□ High blood pressure □ Low blood pressure □ Chest pain □ Fainting
□ Irregular heart beat □ Difficulty in breathing □ Blood clots □ Phlebitis
□ Cold hands or feet □ Swelling of hands □ Swelling of feet
□ Varicose or spider veins □ Palpitations □ Palpitations at rest
□ Any other heart of blood vessel problems?____________________________________

RESPIRATORY:
□ Cough □ Coughing blood □ Asthma □ Bronchitis
□ Pneumonia □ Pain with deep breath □ Chest tightness
□ Difficulty breathing when lying down
□ Phlegm production, what color?____

GASTROINTESTINAL:
□ Nausea □ Vomiting □ Diarrhea □ Constipation
□ Gas □ Belching □ Black stools □ Blood in stools
□ Indigestion □ Bad breath □ Rectal pain □ Hemorrhoids
□ Bleeding gums □ Food stagnation □ Bloating/edema □ Acid reflux/GERD
□ Hernia □ Excessive appetite □ Poor appetite □ IBS/Crohn's disease
□ Colitis □ Slow digestion □ Abdominal pain/cramps
□ Chronic laxative use □ Loose stools, more than 2 per day
□ Any other problem with Stomach or intestines___________________________________

GENITO-URINARY:
□ Frequent urination □ Blood in urine □ Pain upon urination
□ Urgency to urinate □ Unable to hold urine □ Kidney stones
□ Decrease in flow □ Impotency □ Sores on genitals
□ Any particular color to your urine? _______________________________
□ Do you wake up at night to urinate? If yes, how many times a night? ________________
□ Any other problems with your genital or urinary systems?_____________________________

***Men only section*:**
Date of last prostate checkup ____________________PSA results__________________
Manual prostate exam results____________________
Lab results ____
Related symptoms:
□ Prostate problems □ Delayed stream □ Dribbling □ Incontinence
□ Rectal dysfunction □ Increased libido □ Decreased libido □ Premature ejaculation
□ Back pain □ Groin pain □ Testicular pain

REPRODUCTIVE & GYNECOLOGIC:
***Women only section*:**
Are you pregnant? □ Yes □ No
Is it possible that you are pregnant? □ Yes □ No
Number of pregnancies: ____________ Live Births: ___________ Miscarriages: __________
Abortions: _________________________ Premature births:___________________________________
Age at first menses: ________________ Time period between menses:______________________

Duration of menses:_______________ Last PAP: ____

- ▫ Irregular periods ▫ Painful periods ▫ Clots ▫ Breast lumps
- ▫ Vaginal sores ▫ Vaginal discharge ▫ Vaginal dryness ▫ Endometriosis
- ▫ Uterine fibroids ▫ Polycystic Ovarian disease ▫ Fibrocystic breast tissue
- ▫ Unusual character of blood (heavy, scanty)____

Do you practice birth control? ▫ Yes ▫ No If yes, what type? __________ How long? __________

MUSCULOSKELETAL:

- ▫ Neck pain ▫ Rotator cuff ▫ Knee pain ▫ Foot/ankle pain
- ▫ Muscle pain ▫ Muscle spasm ▫ Muscle weakness ▫ Shoulder pain
- ▫ Hip pain ▫ Sciatica ▫ Bursitis ▫ Hand/wrist pain
- ▫ Carpal tunnel ▫ Sprains/strains ▫ Tendonitis
- ▫ Back pain: Low_____ Middle______ Upper_____
- ▫ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PSYCHOLOGICAL:

- ▫ Seizures ▫ Dizziness ▫ Loss of balance ▫ Areas of numbness
- ▫ Poor memory ▫ Concussion ▫ Poor coordination ▫ Bad temper
- ▫ Anxiety ▫ Depression ▫ Easily susceptible to stress
- ▫ Nervousness ▫ ADD/ADHD ▫ Manic depression

Have you ever been treated for emotional problems? ▫ Yes ▫ No

Have you ever considered or attempted suicide? ▫ Yes ▫ No

Any other neurological or psychological problems?____

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COMMENTS: *Please tell us briefly of any other problems you would like to discuss. Use back of sheet if more space needed.*

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