



# Unity Acupuncture & Herbal Medicine

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## HEALTH HISTORY

*Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.*

<b>Name:</b> _____ <small>(first) (middle) (last)</small>	<b>Date:</b> _____	
<b>Date of Birth:</b> _____	<b>Gender:</b> _____	<b>Age:</b> _____
<b>Address:</b> _____		
<b>City:</b> _____	<b>State:</b> _____	<b>Zip:</b> _____
<b>Best Phone:</b> _____	<b>Other Phone (please specify):</b> _____	
<b>E-Mail:</b> _____		
<b>Marital Status:</b> Single    Married    Partner/Live-In    In a Relationship    Separated    Divorced    Widower		
<b>Physician:</b> _____	<b>Phone:</b> _____	
<b>In Emergency Notify:</b> _____	<b>Phone:</b> _____	
<b>How did you hear about Unity Acupuncture and Herbal Medicine?</b> _____		
<b>Referred by:</b> _____	<b>Your Occupation:</b> _____	
<b>Have you tried acupuncture before (circle one)?</b> Yes    No		

**What is your MAIN CONCERN?** \_\_\_\_\_

**Symptoms** \_\_\_\_\_

**Western Diagnosis, if any:** \_\_\_\_\_

**When did you first notice symptoms?** \_\_\_\_\_

**What makes your condition better?** \_\_\_\_\_

**What makes your condition worse?** \_\_\_\_\_

**GENERAL HISTORY**

Significant Trauma (physical or emotional; please list age or date)

Your

Birth History (prolonged labor, forceps delivery, C-section delivery, complications, postpartum depression in mother, etc.)

Childhood Illness: Mumps Measles Rubella Diphtheria Chicken Pox Rheumatic Fever Polio  
Other:

Do you have any infectious diseases?  Yes  No If yes, please identify: \_\_\_\_\_

Hospitalizations/Surgeries/Accidents (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs (with dosages, if you know them)

**Exercise**

Days per week Length of workout Type of Activity

**Diet**

Meals per day Snacks Cravings Are you happy with your weight?

**Beverages (list # of cups/cans per day)**

Coffee  Tea  Soda  Alcohol (drinks per week)

**Tobacco/Drugs**

Tobacco Type: Amount: # of years:

Recreational Drugs Type: Frequency:

Stress level Low Med High

Do you have adequate physical and emotional support at home to meet the challenges of your present condition? Yes No

**Personal History** Please check any conditions or symptoms you have now.

- Stroke
- Heart Disease
- High/Low Blood Pressure
- High Cholesterol
- Cancer
- Diabetes
- Hyper/Hypothyroidism
- Food Allergies/Intolerance
- Gastritis/Pancreatitis
- Irritable Bowel Syndrome
- Crohn's Disease
- Diverticulitis
- Hepatitis
- HIV/AIDS
- Kidney Disease
- Seizures
- Chronic Fatigue
- Anemia
- Raynaud's Disease
- Lyme Disease
- Chronic Pain Condition
- Asthma
- Respiratory Allergies
- Emphysema
- Tuberculosis
- Lupus
- Rheumatoid Arthritis
- Osteoarthritis
- Infertility
- Impotence
- Alcoholism/Substance Abuse
- Other: \_\_\_\_\_

## General

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Poor Sleeping      | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Peculiar tastes/smells |
| <input type="checkbox"/> Chills                 | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Sweats Easily      | <input type="checkbox"/> Tremors                |
| <input type="checkbox"/> Frequent colds or flus | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Dizziness              |
| <input type="checkbox"/> Bleed/Bruise easily    | <input type="checkbox"/> Weight loss/gain   | <input type="checkbox"/> Strong thirst      | <input type="checkbox"/> Sudden energy drop     |

## Skin and Hair

- |   |                                      |  |   |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis   | <input type="checkbox"/> Itching              |
| <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Hair Loss                   | <input type="checkbox"/> Recent moles         |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing        |
| <input type="checkbox"/> Dermatitis         | <input type="checkbox"/> Warts       | <input type="checkbox"/> Fungal Infection            | <input type="checkbox"/> Weak or ridged nails |

## Head, Eyes, Ears, Nose and Throat

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Migraines                    | <input type="checkbox"/> Glasses              | <input type="checkbox"/> Tearing/Dry Eyes      |
| <input type="checkbox"/> Eye Strain             | <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Poor vision          | <input type="checkbox"/> Night Blindness       |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Blurred vision        |
| <input type="checkbox"/> Earaches               | <input type="checkbox"/> Ringing in ears              | <input type="checkbox"/> Poor hearing         | <input type="checkbox"/> Sinus problems        |
| <input type="checkbox"/> Nose bleeds            | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth       | <input type="checkbox"/> Facial pain           |
| <input type="checkbox"/> Sores on lips/tongue   | <input type="checkbox"/> Dental/gum problems          | <input type="checkbox"/> TMJ/Jaw clicks/locks | <input type="checkbox"/> Difficulty swallowing |

## Cardiovascular

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat   | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Varicose/spider veins  | <input type="checkbox"/> Pressure in chest    | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Spontaneous sweating   | <input type="checkbox"/> Rheumatic fever      | <input type="checkbox"/> Heart murmur        |

## Respiratory

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing                       | <input type="checkbox"/> Coughing blood            | <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Bronchitis              |
| <input type="checkbox"/> Pneumonia                            | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest                  | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down |  | <input type="checkbox"/> Production of phlegm... what color? _____ |  |

## Gastrointestinal

- |  |   |                                       |  |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Gas                 | <input type="checkbox"/> Belching             | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool        |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Rectal pain  | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Bloating/Edema      | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Parasites    | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD     | <input type="checkbox"/> Hernia       | <input type="checkbox"/> Poor appetite         |
| <input type="checkbox"/> Excessive appetite  | <input type="checkbox"/> Significant thirst   | <input type="checkbox"/> Ulcer        | <input type="checkbox"/> Gallstones            |

## Musculoskeletal

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Neck pain                              | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Hand/wrist pain  | <input type="checkbox"/> Carpal Tunnel   |
| <input type="checkbox"/> Knee pain                              | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica   | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain                               | <input type="checkbox"/> Muscle pain     | <input type="checkbox"/> Muscle weakness  | <input type="checkbox"/> Muscle cramps   |
| <input type="checkbox"/> Tendonitis                             | <input type="checkbox"/> Bursitis        | <input type="checkbox"/> Rotator Cuff   | <input type="checkbox"/> Joint Pain      |
| <input type="checkbox"/> Back pain    Low___ Middle___ Upper___ |  | <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) |  |

## Neurological

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory     | <input type="checkbox"/> Concussion        | <input type="checkbox"/> ADD/ADHD          |

## Emotional

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Mood Swings        | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Constant Anxiety            |
| <input type="checkbox"/> Panic Attacks      | <input type="checkbox"/> Situational Anxiety | <input type="checkbox"/> Social Anxiety    | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Irrational Fears   | <input type="checkbox"/> Lack of Motivation  | <input type="checkbox"/> Constant Worrying | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Obsessive Behavior | <input type="checkbox"/> Anger               | <input type="checkbox"/> Manic Depression  | <input type="checkbox"/> Sadness/Grief               |

Have you ever been treated for emotional problems?  Yes  No  
Have you ever considered or attempted suicide?  Yes  No  
Have you ever been treated for substance abuse?  Yes  No

**Genito-Urinary (Men)**

Are you and your partner trying to conceive?  Yes  No

How long have you and your partner been trying to conceive? \_\_\_\_\_

Are you currently undergoing assisted reproductive fertility treatments (IUI, IVF, ICSI, superovulation, etc.)?  Yes  No

If yes, at what clinic? \_\_\_\_\_

How would you define your sexual energy?  Below Normal  Normal  Above Normal

Have you had a recent physical exam?  Yes  No Date of exam? \_\_\_\_\_

Have you ever been diagnosed with or experienced:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Undescended Testicle    | <input type="checkbox"/> Varicocele                | <input type="checkbox"/> Erectile Dysfunction           | <input type="checkbox"/> Difficulty Ejaculating       |
| <input type="checkbox"/> Premature Ejaculation   | <input type="checkbox"/> Nocturnal Emission        | <input type="checkbox"/> Penile Discharge               | <input type="checkbox"/> Sores on Genitals            |
| <input type="checkbox"/> Genital Itch            | <input type="checkbox"/> Small or Soft Testes      | <input type="checkbox"/> Prostate Conditions            | <input type="checkbox"/> Incontinence                 |
| <input type="checkbox"/> Decrease in urine flow  | <input type="checkbox"/> Stop and start urine flow | <input type="checkbox"/> Blood in Urine                 | <input type="checkbox"/> Burning or Painful Urination |
| <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Kidney Stones             | <input type="checkbox"/> STDs If yes, please list _____ |   |

Are you taking testosterone supplements or drugs?  Yes  No

Have you been checked for blockage of your reproductive tract?  Yes  No

Are you trying to conceive?  Yes  No

If yes, what was your sperm count?  Below Normal  Normal  Number: \_\_\_\_\_

What was the sperm mobility:  Below Normal  Normal  Notes: \_\_\_\_\_

What was the sperm morphology?  Abnormal  Normal  Notes: \_\_\_\_\_

**Comments:** Please inform me of any other problems or goals for your health that you would like to discuss.

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