# Vancouver Acupuncture

## HEALTH HISTORY QUESTIONNAIRE

Name:_____ Date_____

What is your primary concern, condition, injury or illness?_____

_____

How long has it bothered you?_____

Describe what caused it/how it started:_____

_____

How does this condition affect you? (Interference with work, sleep, appetite, etc.)_____

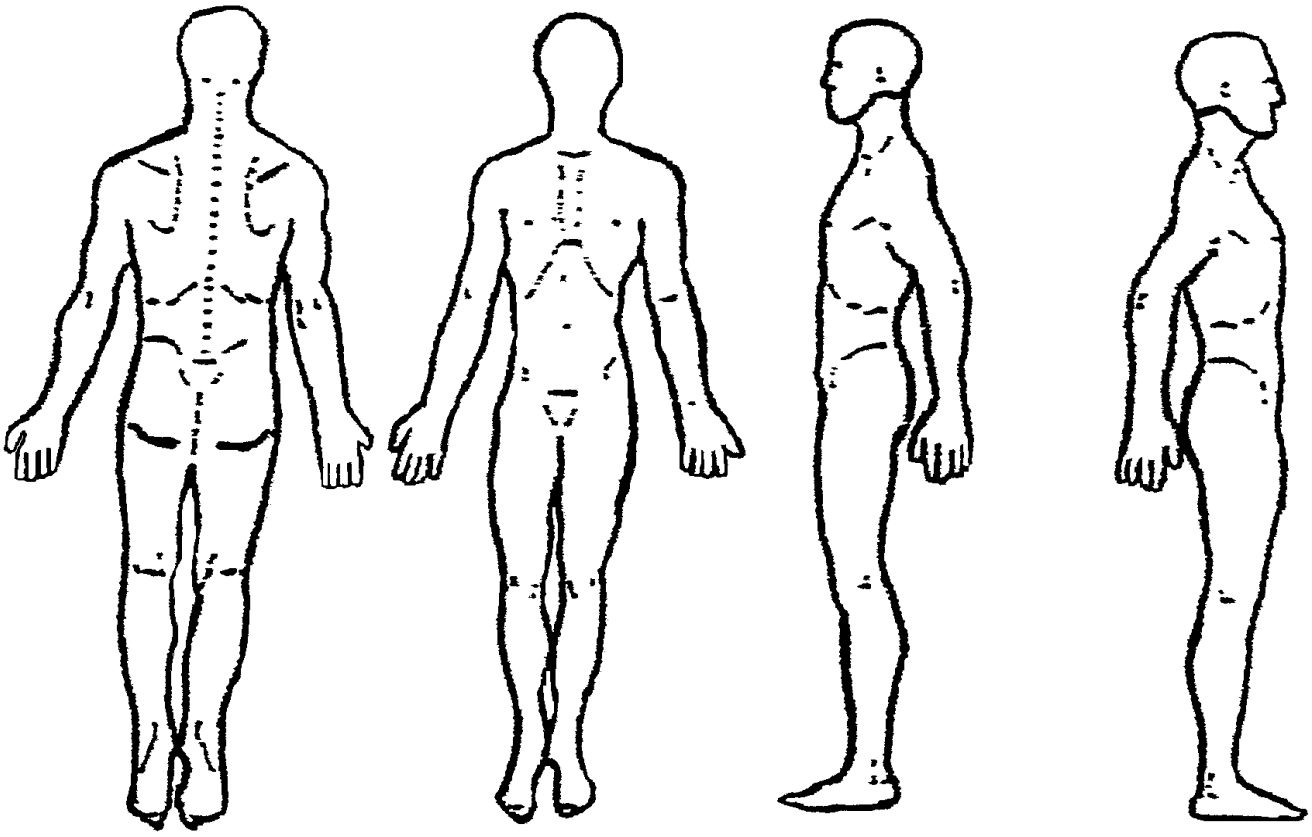
_____

Have you received treatment for this condition?_____ When?_____

From Whom?_____Diagnosis?_____

Has the condition gotten: Better: _____ Worse:_____ Same:_____

**INDICATE PAINFUL OR DISTRESSED AREAS:**



**BACK** **FRONT** **LEFT** **RIGHT**

Please put a check next to conditions that you have experienced within the last three months. Indicate the length of time you have had this condition.

**GENERAL:**

☐ Poor Appetite _____ ☐ Insomnia _____ ☐ Disturbed Sleep _____
☐ Localized Weakness _____ ☐ Cravings _____ ☐ Strong Thirst _____
☐ Weight Gain _____ ☐ Weight Loss _____ ☐ Changes in Appetite _____
☐ Sweating Easily _____ ☐ Tremors _____ ☐ Bleed or Bruise Easily _____
☐ Night Sweats _____ ☐ Fever _____ ☐ Chills _____
☐ Sudden Energy Drop (time of day?) _____ ☐ Poor Balance _____
☐ Other unusual or abnormal conditions you have noticed in your general sense of health?_____
☐ Contagious Conditions_____
☐ Long Term Illness_____

**SKIN & HAIR:**

☐ Rashes _____ ☐ Ulcerations _____ ☐ Hives _____
☐ Itching _____ ☐ Eczema _____ ☐ Pimples _____
☐ Dandruff _____ ☐ Hair Loss _____ ☐ Recent Moles _____
☐ Changes in hair or skin texture _____
Any other hair or skin problems? _____

**HEAD, EYES, EARS, NOSE, THROAT:**

☐ Dizziness _____ ☐ Concussions _____ ☐ Migraines _____
☐ Glasses _____ ☐ Spots in Front of Eyes _____ ☐ Eye Pain _____
☐ Poor Vision _____ ☐ Night Blindness _____ ☐ Color Blindness _____
☐ Cataracts _____ ☐ Blurry Vision _____ ☐ Earaches _____
☐ Ringing in Ears _____ ☐ Poor Hearing _____ ☐ Eyestrain _____
☐ Sinus Problems _____ ☐ Recurrent Sore Throat _____ ☐ Nose Bleeds _____
☐ Grinding Teeth _____ ☐ Sores on Lips/Tongue _____ ☐ Facial Pain _____
☐ Teeth Problems _____ ☐ Headaches _____ ☐ Jaw Clicks _____
Any other head or neck problems? _____

**CARDIOVASCULAR:**

☐ Dizziness _____ ☐ Low Blood Pressure _____ ☐ Chest Pain _____
☐ Irregular Heartbeat _____ ☐ High Blood Pressure _____ ☐ Fainting _____
☐ Cold Hands/Feet _____ ☐ Swelling of Hands _____ ☐ Swelling of Feet _____
☐ Blood Clots _____ ☐ Difficulty Breathing _____ ☐ Phlebitis _____
Any other heart or blood vessel problems? _____

**RESPIRATORY:**

☐ Cough _____ ☐ Coughing up Blood _____ ☐ Asthma _____
☐ Bronchitis _____ ☐ Pain w/ Deep Inhalation _____ ☐ Pneumonia _____
☐ Difficulty Breathing when Lying Down _____
☐ Production of Phlegm (color?) _____
Any other lung problems? _____

**GASTROINTESTINAL:**

☐ Nausea _____ ☐ Vomiting _____ ☐ Diarrhea _____
☐ Constipation _____ ☐ Gas _____ ☐ Belching _____
☐ Black Stools _____ ☐ Blood in Stools _____ ☐ Indigestion _____
☐ Bad Breath _____ ☐ Rectal Pain _____ ☐ Hemorrhoids _____
☐ Abdominal Pain/Cramps _____ ☐ Chronic Laxative Use _____
Any other problems with stomach or intestines? _____

**GENITO-URINARY:**

☐ Pain on Urination _____ ☐ Frequent Urination _____ ☐ Blood in Urine _____
☐ Urgency to Urinate _____ ☐ Unable to Hold Urine _____ ☐ Kidney Stones _____
☐ Decrease in Flow _____ ☐ Impotence _____ ☐ Sores on genitals _____
Do you wake up at night to urinate? _____ If so, how often? _____
Any particular color to your urine? _____
Any other problems with your genital/urinary functions? _____

**REPRODUCTIVE & GYNECOLOGIC:**

☐ Menstrual Clots _____ ☐ Painful Menses _____ ☐ Unusual Menses _____
☐ Changes in body/psyche prior to menstruation _____ Duration _____
☐ Irregular Menses _____ ☐ Menopause (Age) _____ ☐ Other Problems _____
Age at 1st Menses _____ Time between Menses _____ Duration _____
First day of last Menses _____ # of Pregnancies _____ # of Births _____
Miscarriages _____ Abortions _____ Premature Births _____
Birth Control? _____ If so, type? _____ How Long? _____

**MUSCULOSKELETAL:**

☐ Neck Pain _____ ☐ Muscle Spasms _____ ☐ Knee Pain _____
☐ Back Pain _____ ☐ Muscle Weakness _____ ☐ Foot/Ankle Pain _____
☐ Hand/Wrist Pain _____ ☐ Shoulder Pain _____ ☐ Hip Pain _____
Any other joint/bone problems? _____

**NEUROPSYCHOLOGICAL:**

☐ Seizures _____ ☐ Dizziness _____ ☐ Loss of Balance _____
☐ Area of Numbness _____ ☐ Poor Memory _____ ☐ Lack of Coordination _____
☐ Concussion _____ ☐ Depression _____ ☐ Anxiety _____
☐ Bad Temper _____ ☐ Easily Susceptible to Stress _____
Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological/psychological problems? _____

**LIFESTYLE:**

Do you follow a regular exercise program? _____
Please describe your average daily diet: _____
_____
☐ Cigarette Smoking _____ ☐ Coffee, Tea & Cola _____☐ Alcoholic Beverages _____
Prescription medications taken within the last two months: _____
_____
Other Supplements:_____
Surgeries: _____

Vancouver Acupuncture

## PATIENT INFORMATION

| | |
|---|---|
| **Name:** | **Birthdate: Age:** |
| **Address:** | **Gender: M F** |
| **City: State: Zip:** | **Height:** |
| **Home Phone: ( )** | **Weight:** |
| **Cell Phone: ( )** | **Marital Status: M S D W** |
| **Occupation:** | **Emergency Contact Name:** |
| **Employer:** | **Emergency Contact Phone:** |
| **Email Address:** | **Referred by:** |
| | |

## Financial Policy

Payment is expected at time of service. If your insurance covers acupuncture, we will submit the claim to your insurance company. Our insurance quote is not a guarantee of payment. Vancouver Acupuncture Clinic accepts cash, Visa, Mastercard, or personal check. Your appointment time is reserved specifically for you. Please provide at least 24 hours notice if you must cancel an appointment. Otherwise, you will be charged a missed appointment fee of $25.

**Patient's Signature: (or Guardian, if Minor): _____Date:_____**

## Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have read and understand Vancouver Acupuncture Clinic's notice of Privacy Practices, and that I may request a copy of the privacy practices document at any time. This notice describes how Vancouver Acupuncture may use and disclose my protected health information, particular restrictions pertaining to the use and disclosure of my healthcare information, and the rights I may have with regards to my protected health information.

**Patient's Signature: (or Guardian, if Minor): _____Date:_____**

We are able to provide email and/or text reminders two days prior to your appointment.
Would you like an email reminder? **Y / N**
Would you like a text reminder? **Y / N**