Green Point Acupuncture

Health History Questionnaire and Registration

Patient Information

Full Name ________________________________

Gender___________ Date of Birth ____________

Address__________________________________

____

Occupation ______________________________

Have you ever had acupuncture before ______

How did you hear about us ________________

Contact Information

Phone Number _____________________________

E-mail _____________________________________

Emergency Contact Name

____

Phone Number _____________________________

Health History

- ❖ Your main complaint

____

- ❖ When did the problem begin

____

- ❖ Please note the degree of severity of your problem now:

- ❖ Have you been given a diagnosis for this problem? If so, what

____

- ❖ What kinds of treatment you tried

____

- ❖ List past accidents & surgeries

____

- ❖ Check illness that you have had in the past

□ HIV/AIDS □ Allergies □ Cancer □ Diabetes
□ Hepatitis □ Bleeding disorders □ Heart disease
□ Seizures □ High or Low Blood Pressure
□ Other ___________________

- ❖ How long has it been since you have had a complete medical exam?

  ____

- ❖ Check illnesses that have occurred in blood relatives.

□ Diabetes □ High blood pressure □ Stroke
□ Cancer □ Heart disease □ Kidney disease
□ Other ___________________

- ❖ Check ongoing health condition you have had in the last three months

General

□ Cold sensation in body
□ Cold sensation in hands and feet
□ Heavy sensation in body
□ Easy tiredness
□ Easy sweating
□ Night sweating
□ Hot sensation in body
□ Hot sensation only in palms and soles
□ Easy bleeding
□ Thirst, liking cold drinks
□ Thirst, no desire to drink

Muscle/Joint/Bone Pain

□ Fixed pain
□ Restricted movement
□ Loss of strength
□ Local burning sensation
□ Local cold sensation
□ Sudden onset
□ Stabbing pain
□ Dull pain
□ Aggravated in rainy or cloudy days
□ Aggravated at night
□ Relieved by pressure
□ Resist touch

Eyes/Ear/Nose/Throat

□ Blurred or failing vision
□ Spots in front of eyes
□ Eye dryness
□ Earache
□ Ear ringing
□ Nose bleeds
□ Nasal discharge
□ Sore throat
□ Itchy throat
□ Eye pain
□ Excessive tear
□ Poor hearing
□ Discharge from ear
□ Nasal congestion
□ Dizziness
□ Migraines
□ Headache
□ Hoarse voice

Skin

□ Boils
□ Dry skin
□ Itching/rash
□ Sensitive skin
□ Ulceration
□ Loss of hair
□ Other __________

Genital/Urinary

□ Clear urine
□ Yellow urine
□ Scanty urine
□ Blood/pus in urine
□ Pain on urine
□ More than once at night
□ Inability to control urine
□ Lowered libido
□ Weakness of lumbar and knees
□ Edema of legs
□ Burning sensation in urination
□ Difficult urination

Men Only

□ Erection difficulties
□ Penis discharge
□ Weak erection
□ Impotence
□ Seminal emission
□ Premature ejaculation

Cardiovascular/Respiratory

□ Fullness in chest
□ Pain in chest
□ Rapid/irregular heart beat
□ Scanty phlegm
□ Bloody phlegm
□ Cough
□ Difficulty breathing
□ Asthma/wheezing
□ Yellow phlegm
□ Clear phlegm
□ Profuse phlegm

Gastrointestinal

□ Belching
□ Difficulty swallowing
□ Poor appetite
□ Excessive hunger
□ Pain over stomach
□ Abdominal distention
□ Bearing down sensation
□ Bitter taste in mouth
□ Lack taste in mouth
□ Sour taste in mouth
□ Hypochondria distention
□ Smelly gas
□ Heartburn
□ Nausea
□ Vomiting
□ Bad breath
□ Blood in stools
□ Black stools
□ Dry stools
□ Loose stools
□ Smelly stools
□ Diarrhea in early morning

Neuropsychological

□ Dream-disturbed sleep
□ Difficulty in focusing
□ Mental restlessness
□ Anxiety
□ Nervousness
□ Easy anger
□ Poor sleep
□ Excess sleep
□ Poor memory
□ Depression
□ Easy sighing
□ Excessive fear

Women Only

□ Early menses
□ Delayed menses
□ Irregular menses
□ Profuse menses
□ Scanty menses
□ Clotted menses
□ Extreme menstrual pain
□ Previous miscarriage
□ Days of menses cycle ____
□ Breast distending pain before menses
□ Clear and thin vaginal discharge
□ Yellow vaginal discharge
□ Smelly vaginal discharge
□ Pregnant

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature ________________________________ Date ______________________