BRIO Acupuncture · Rehabilitation Chinese Sports Medicine

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_____ Date_____

Street_____City_____ State/Zip_____

Home Phone_____Cell Phone_____Email_____

Age_____Date of Birth_____Male_____Female_____Height_____Weight_____

Marital Status ☐Married ☐Never Married ☐Widowed ☐Divorced

Education ☐Grammar School ☐High School ☐College ☐Masters

Occupation_____Retired_____Disabled_____Unemployed_____

Family Physician_____Referred by_____

Emergency Contact_____Emergency contact phone number_____

Have you ever been treated with acupuncture or Oriental medicine before?

Main problem you would like us to help you with_____

_____

_____

_____

When did the 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 address_____

Past personal medical history ☐Asthma ☐Allergies ☐Diabetes
☐ Cancer ☐Stroke ☐Heart Disease ☐High Blood Pressure
☐ Seizures ☐Hepatitis ☐Rheumatic Fever ☐Thyroid Disease
☐ Venereal Disease ☐Other:_____

Hospitalizations/Surgeries (include dates)_____

Significant Trauma (auto accients, falls, etc)_____

Allergies (drugs, chemicals, metals, foods)_____

Medications 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? ☐No ☐Yes
If yes, please describe_____

Describe your average daily diet:
Morning_____
Afternoon_____
Evening_____

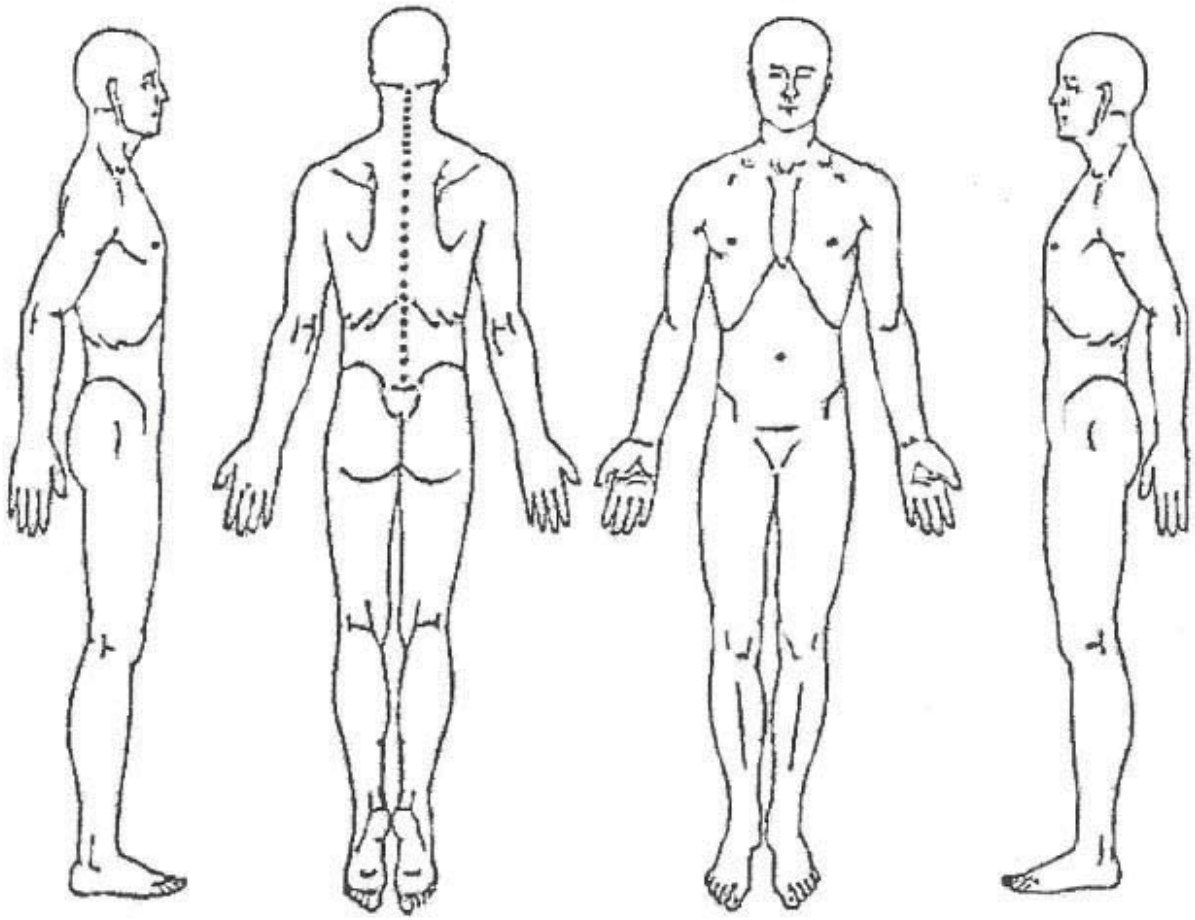
Do you smoke? ☐ No ☐Yes If yes, what and how much?_____

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

How many 8 oz. glasses of water do you drink per day/week?_____

How many alcoholic beverages do you drink per day/week?_____

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
☐ Strong thirst for ☐ hot drinks ☐ cold drinks
☐ Sudden energy drop: 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
☐ 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 or 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?_____

REPRODUCTIVE & GYNECOLOGIC:
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?_____
_____

COMMENTS: Please tell us briefly of any other problems you would like to discuss.
_____
_____
_____
_____
_____
_____
_____