Connecticut Center For Natural Health
210 South Main Street, Middletown, CT 06457
phone: (860)347-8600 fax: (860)347-8434
www.yournaturalhealth.com

CONFIDENTIAL HEALTH HISTORY QUESTIONAIRE

Please take the time to fill out this questionnaire to the best of your ability. Please add details when relevant. All responses are kept confidential.

NAME:_____ DATE:_____
DOB:_____
ADDRESS (include street, apt. #, city, state, zip)
_____
_____
EMAIL:_____ Is it ok to email confidential information and reminders? (Y/N)
HOME PHONE:_____ WORK:_____ CELL:_____
Is it ok to leave a text message, appointment reminder, or voicemail at any of the above numbers? (Y / N)
AGE:_____ HEIGHT:_____ WEIGHT_____ OCCUPATION:_____
FAMILY PHYSICIAN:_____ Phone number:_____
HEALTH INSURANCE COMPANY:_____
EMERGENCY CONTACT (name, phone number, and relation to you-please list guardian if under 18)
_____
HOW DID YOU HEAR ABOUT THIS OFFICE? _____
HAVE YOU EVER RECEIVED ACUPUNCTURE BEFORE?_____

MAIN PROBLEM:

What has brought you to *To The Point Acupuncture, LLC*?
Please include: To what extent this problem interferes with daily activities, how long ago this problem began, what aggravates or alleviates this condition, diagnosis (if any) given for this problem, and other treatment you have tried.

_____
_____
_____
_____
_____

PATIENT MEDICAL HISTORY:

RECENT TESTS:

☐ Physical	☐ Cholesterol	☐ Mammography	☐ Pap Smear
☐ Blood	☐ HIV/STD	☐ Prostate	☐ Other:_____

Test results and dates:_____

PAST AND PRESENT MEDICAL HISTORY: (please check all applicable)

☐ HIV	☐ STD	☐ Tuberculosis	☐ Cancer	☐ PTSD
☐ Bleeding Tendency	☐ Anemia	☐ Blood disorders	☐ Heart disease	☐ Rubella
☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes	☐ Low blood sugar/hypoglycemic	
☐ Glaucoma	☐ Thyroid disease	☐ Kidney stones	☐ Multiple Sclerosis	
☐ Polio	☐ Measles	☐ Mumps	☐ Rheumatic fever	
☐ Chicken Pox	☐ Mononucleosis	☐ Epilepsy	☐ Seizures	☐ Gout
☐ Hepatitis	☐ Gallbladder stones	☐ Jaundice	☐ Fatty liver/Liver disease	

FAMILY MEDICAL HISTORY:

☐ High Blood Pressure	☐ Heart Disease	☐ High Cholesterol	☐ Stroke	☐ Cancer
☐ Diabetes	☐ Seizures	☐ Mental illness	☐ Allergies	☐ Other:_____

Current Medications/Herbs/Vitamins/Supplements:
(please include dosage, when began taking, how often, and reason for taking):

_____

_____

_____

Allergies (drugs, chemicals, foods)

_____

Please list any Hospitalizations/Surgeries/Significant Trauma/Major illness or disease:

_____

_____

_____

Any implants, devices, or prosthetics (metal or plastic)?

LIFESTYLE:

Caffeine (intake per day):_____ **Water** (intake per day):_____

Smoking/Chew (# of packs/day):_____ **Alcohol** (# of drinks daily):_____ **Recreational Drugs:** (Y / N): _____

How many hours per week do you work?_____

Do you have a regular exercise program? (type of exercise and times per week)_____

	Lowest									Highest
Stress Level:	1	2	3	4	5	6	7	8	9	10
Energy Level:	1	2	3	4	5	6	7	8	9	10

OVERALL TEMPERATURE:

☐ Cold hands/feet	☐ Raynaud's disease	☐ Cold abdomen
☐ Cold body temp. (sensation)	☐ Hot body temp. (sensation)	☐ Night sweats
☐ Sweaty hands/feet	☐ Heat in hands, feet, chest	☐ Hot flashes (any time of day)
☐ Spontaneous sweating	☐ Lack of perspiration	☐ Chills

SKIN & HAIR

☐ Dry	☐ Oily	☐ Acne	☐ Dandruff	☐ Loss of hair
☐ Eczema/Psoriasis	☐ Itching	☐ Rashes	☐ Hives	☐ Ulcerations
☐ Lumps/cysts	☐ Warts	☐ Recent moles		

☐ Change in hair or skin texture?

☐ Any other hair or skin problems:_____

HEAD, EYES, EARS, NOSE, MOUTH and THROAT:

☐ Glasses/Contacts	☐ Night blindness	☐ Dizziness/Vertigo	☐ Facial pain
☐ Blurry vision/Eye strain	☐ Color blindness	☐ Sinus problems	☐ Nose bleeds
☐ Tearing/Dryness	☐ Hearing loss	☐ TMJ/Jaw problems	☐ Recurrent sore throats
☐ Floaters/spots	☐ Ear ringing/Tinnitus	☐ Teeth grinding/clenching	☐ Sores on lips/tongue
☐ Cataracts	☐ Earaches/infections	☐ Teeth problems	☐ Bleeding gums
☐ Concussions	☐ Headaches/Migraines (location on head/frequency):_____		

☐ Any other face or head problems: _____

CARDIOVASCULAR:

☐ Irregular heart beat ☐ Chest pain/tightness ☐ Palpitations
☐ High blood pressure ☐ Low blood pressure ☐ Varicose veins
☐ Swelling of the hands/feet ☐ Blood clots ☐ Murmur
☐ Phlebitis ☐ Fainting ☐ Pacemaker
☐ Any other heart or blood vessel problems:_____

RESPIRATORY:

☐ COPD ☐ Persistent cough ☐ Difficulty breathing/Shortness of breath
☐ Emphysema ☐ Asthma ☐ Frequent colds
☐ Bronchitis ☐ Coughing blood ☐ Pain with a deep breath
☐ Pneumonia ☐ Post nasal drip ☐ Allergies
☐ History of smoking (How long did you smoke for? When did you quit?)_____
☐ Production of phlegm- color?_____ ☐ Any other lung/breathing problems:_____

DIET:

☐ Strong thirst ☐ No thirst ☐ Water retention ☐ Particular tastes/smells
☐ Weight gain ☐ Weight loss ☐ Increase/decrease in appetite
☐ Cravings:_____
Do you follow a prescribed diet or have food restrictions/sensitivities? _____
AVERAGE DAILY DIET:

BREAKFAST:	LUNCH:	DINNER:	SNACKS:

GASTROINTESTINAL:

☐ Passing gas ☐ Belching ☐ Heartburn/Acid reflux/GERD
☐ Ulcers ☐ Abdominal bloating ☐ Abdominal/Epigastric Pain
☐ Nausea ☐ Vomiting ☐ IBS ☐ Crohn's disease
☐ Polyps ☐ Diverticulitis ☐ Colitis
☐ Any other problems with your stomach or intestines:_____

ELIMINATION/BOWELS:

☐ Constipation ☐ Diarrhea ☐ Loose stools ☐ Black stools/blood in stool
☐ Hemorrhoids ☐ Rectal pain ☐ Undigested food in stools ☐ Chronic laxative use
☐ How often do you have a bowel movement?_____ ☐ Strong odor

URINARY:

☐ Pain upon urination ☐ Frequent urination ☐ Blood in urine
☐ Urgency to urinate ☐ Unable to hold urine ☐ Incontinence
☐ Decrease in flow ☐ Frequent UTI or bladder infections ☐ Cloudy urine
☐ Scanty urination ☐ Profuse urination ☐ Strong odor
☐ Do you wake to urinate? How often?_____ Color of urine:_____
☐ Any other problems with your urinary system:_____

Libido: ☐ High ☐ Normal ☐ Low ☐ Pain during or after intercourse

MALE REPRODUCTIVE:

☐ Erectile Dysfunction ☐ Prostate problems ☐ Testicular pain/swelling
☐ Impotence ☐ Premature ejaculation ☐ Cold/numbness in external genitals
☐ Any other problems with your reproductive system:_____

FEMALE REPRODUCTIVE:

☐ Are you pregnant?_____ ☐ Is it possible you are pregnant?_____ ☐ Difficulty Conceiving
☐ Live Births#_____ ☐ Premature births#_____ ☐ Miscarriages#_____ ☐ Abortions#_____
Of the live births, were there any problems or complications during the pregnancy or during delivery? _____
_____
☐ Last PAP:_____ ☐Birth control? What type and for how long_____
☐ Fibrocystic breasts ☐ Yeast infections ☐ Vaginal dryness ☐ Vaginal Discharge - Color:_____

MENSTURAL CYCLE:

☐ Age of first menses _____ ☐ Duration of menses _____ ☐ Time between menses_____
☐ Light flow ☐ Medium flow ☐ Heavy flow
☐ Clotting ☐ Irregular cycles ☐ Bleeding between periods ☐ Spotting
☐ Color of the blood:_____
☐ Cysts ☐ Endometriosis ☐ Polyps ☐ Fibroids
PMS:
☐ Breast tenderness ☐ Moodiness ☐ Cramping ☐ Bloating/water retention ☐ Headaches

MENOPAUSE:

☐ Menopause Age:_____ ☐ Menopausal Symptoms (please describe):_____
☐ Any other problems with your reproductive system:_____

SLEEP:

☐ Hard time falling asleep ☐ Hard time staying asleep ☐ Insomnia
☐ Vivid dreams ☐ Night terrors ☐ Restless
How many hours of sleep per night do you get?_____ Do you wake feeling rested? (Y / N)

MUSCULOSKELETAL:

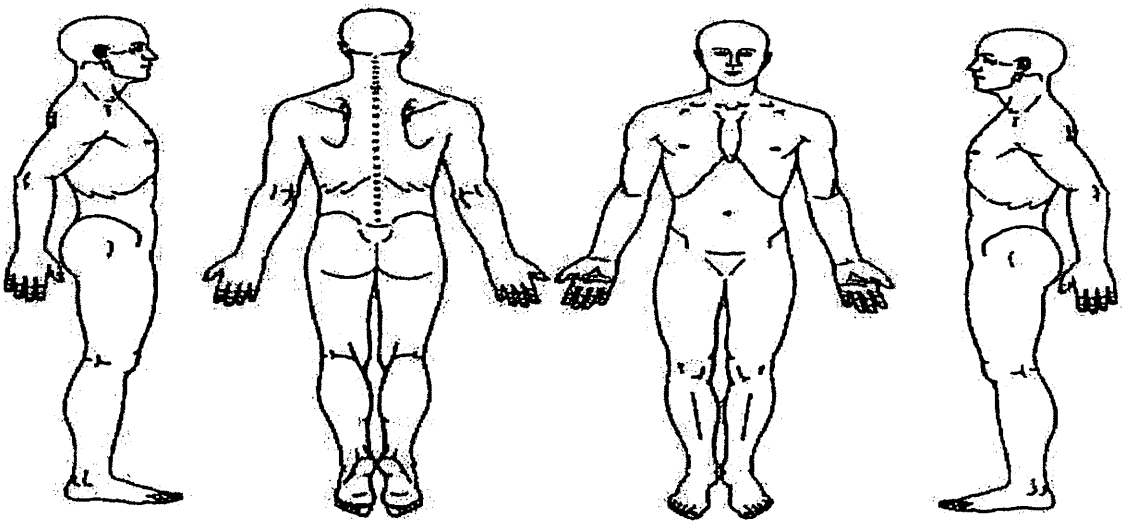
☐ Neck/Upper Back Pain ☐ Shoulder Pain ☐ Hip Pain
☐ Mid Back Pain ☐ Arm Pain ☐ Leg Pain
☐ Low Back Pain ☐ Hand/Wrist Pain ☐ Foot/Ankle Pain
☐ Joint Pain (location):_____

QUALITY OF PAIN:

☐ Sharp ☐ Dull ☐ Burning ☐ Fixed ☐ Moving ☐ Achy ☐ Cramping
☐ Other:_____

	Lowest									Highest
Pain Level:	1	2	3	4	5	6	7	8	9	10

Please mark areas of pain with an X:



WHAT MAKES THE PAIN **BETTER**:

☐ Pressure ☐ Heat ☐ Cold ☐ Exercise ☐ Other:_____

WHAT MAKES THE PAIN **WORSE**:

☐ Pressure ☐ Heat ☐ Cold ☐ Exercise ☐ Other:_____

☐ Does weather affect the pain: Type of weather:_____

☐ Any other muscle, joint, or bone problems:_____

NEUROLOGICAL:

☐ Stroke ☐ Paralysis ☐ Numbness/Tingling

☐ Loss of Balance ☐ Seizures/Epilepsy ☐ Dizziness ☐ Poor Memory

☐ Any other neurological problems:_____

EMOTIONAL/PSYCHOLOGICAL:

☐ Anxiety ☐ Depression ☐ Bad Temper/irritable ☐ Panic attacks

☐ Over-thinker/worry ☐ Grief/sadness ☐ Fear ☐ Easily susceptible to stress

☐ Bipolar ☐ Manic depressive

☐ Have you ever been treated for any mental or emotional conditions:_____

☐ Have you ever attempted or considered suicide:_____

☐ Any other emotional issues/concerns:_____

Comments:

Please let me know of any other problems you would like to discuss

_____

_____

_____

_____

_____

_____