

HISTORY QUESTIONNAIRE

NOTE: Many factors must be considered in designing a complete health-building program. Treating the whole person requires attention to all symptoms and conditions. Often minor symptoms are major clues to delicate biochemical, energetic or somatic imbalances. Please complete the questionnaire as carefully as you can. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME _____ DATE _____ CASE NO _____
ADDRESS _____ RES. PHONE _____
CELL PHONE _____ EMAIL ADDRESS: _____
EMPLOYER _____ BUS. PHONE _____
PRIMARY CARE PHYSICIAN & PHONE _____
OCCUPATION _____ REFERRED BY: _____
AGE ___ BIRTH DATE _____ M F M S D W SPOUSE CHILD

Is your condition due to an accident an illness Other _____

Did your accident occur while at work? Yes No When _____

Were you involved in an automobile accident? Yes No When _____

STATE your present complaint, injury or illness: _____

When did it begin? (Date) _____ Describe what caused it: _____

What makes it better? _____

What makes it worse? _____

Is it getting worse? Yes No Does it interfere with: Work Sleep Daily Routine Other
Explain: _____

Who have you previously consulted about your present problems? _____

Secondary Complaints: _____

Previous Medical Care: _____

Operations: Please indicate all surgeries, type and year _____

Have you ever been advised to have any surgery which was not done? _____

Have you been hospitalized for anything other than surgery? _____

TREATMENT FOR OTHER CONDITIONS: _____

PERSONAL HISTORY: Have you ever had/do you currently have:

- Scarlet Fever Jaundice Rheumatic Fever Gonorrhea/Syphilis Pneumonia Anemia
- Rectal Disease Gallbladder Disease Pleurisy Epilepsy Bladder Disease Diabetes
- Polio/Meningitis Nephritis Cancer Nervous Breakdown Food/Drug Poisoning
- TB/Angina Hay Fever/Asthma Boils/Infections Heart Disease Hepatitis Alcoholism
- High Blood Pressure Miscarriage Mental disorder Drug problem A.I.D.S.

FAMILY HISTORY: Has your father or mother ever had:

- Cancer Stroke Scoliosis Kidney Disease Glaucoma TB Epilepsy Diabetes
- Mental Disorder Heart Trouble Asthma Ulcers Arthritis Alcoholism
- High Blood Pressure Drug problem Allergies Other _____

Is there any familial disease tendency of which you are aware: _____

INJURIES: (Auto accidents, falls, etc.) _____

- Broken Bones Concussion or Head Injury Dislocations Sprains Loss of Consciousness

Name: _____ Date: _____

PAST MEDICAL HISTORY

Birth: Anything significant about your birth?

Vaccination history: Any reaction that you remember?

Childhood illnesses: Any surgery or accidents? List in chronological order and indicate length of illness or injury.

Age 0-6:

Age 7-12:

Age 13-20:

Age 21-30:

Age 31-40:

Age 41 to present:

Family health history:

Name: _____ Date: _____

FEMALES ONLY

Are you or might you be pregnant? Yes No Maybe If yes, what month? _____
What method of birth control do you use? _____
Are you experiencing reduced sexual energies? Yes No Other difficulties? Yes No
Explain: _____
Do you have regular PAP tests? Yes No How regular? _____

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

Menstrual Cycle

Age started: _____ Age stopped: _____
 Irregular _____
 Painful _____
 Excess blood _____
 Lack of blood _____
 Dark _____
 Light _____
 Heavy clotting _____
 Water retention _____
 Painful breast _____

Vaginal Discharge:

Liquid _____
 Yellow _____
 Thick _____
 Bad odor _____
 White _____
 Other _____

Gynecological History or Operations:

Ovaries _____
 Uterus _____
 Tubes _____
 Vagina _____
 Breast _____
 Other _____

Pregnancy:

Total Number: _____
Number of children: _____
Number of abortions: _____
Number of miscarriages: _____
Complications: _____

MALES ONLY

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

Reduced sexual energies: _____
 Premature ejaculation: _____
 Seminal emission: _____
 Impotence: _____
 Discharges: _____
 Pain associated with genitals: _____
 Other: _____

Name: _____ Date: _____

PATIENT PROFILE

It is very important to know how long a patient has experienced his/her symptoms. Thus, it is essential to indicate time on the symptoms.

Indicate with one check any condition that you sometimes experience; use two checks for those which often occur, and three checks for symptoms that are a major concern.

WATER ELEMENT

- Hearing loss
- Dizziness
- Lower backache/neck pain
- Sinus congestion
- Edema
- Darkness under the eyes
- Emotional instability
- Aversion to cold
- Hair thinning or loss
- Premature aging
- Frequent urination
- Kidney stones
- Perspire very easily
- Weakness of legs/knees
- Asthmatic cough
- Rapid weight change
- Loose teeth
- Reduced sexual energy
- Thyroid problems
- Diabetes

WOOD ELEMENT

- Headaches
- Migraines
- Ringing in the ears
- Poor eyesight
- Eye infections
- Dry eyes
- Eczema
- Shingles
- Herpes simplex
- Warts
- Nervousness
- Convulsion, spasms
- Irritability
- Constipation
- Hemorrhoids
- Hepatitis

- Ulcer
- Vomiting
- Gallstones
- Indecisive
- Fullness below ribs
- Shoulder/neck tension
- Insomnia 11 P.M. - 3 A.M.

FIRE ELEMENT

- Dry scalp
- Skin eruptions, rashes
- Cysts, tumors
- Ear infections
- Sore throat, tonsillitis
- Lymphatic swelling
- Hot palms and soles
- Heart palpitations
- Aversion to heat
- Bitter taste in mouth
- Gum problems
- Nose bleed
- Facial redness
- Itching/burning skin
- Hot hands/feet
- Thirst
- Vivid dreaming
- Dark urine
- Night sweats

EARTH ELEMENT

- Indigestion
- Flatulence
- Food allergy
- Stomach ache/ulcer
- Diarrhea
- Anemia
- Halitosis
- Sores in mouth
- Heartburn
- Strong appetite

- Weak appetite
- Nausea
- Abdominal bloating
- Low body weight

METAL ELEMENT

- Bronchitis
- Asthma
- Shallow breathing
- Cough
- Sinus congestion
- Nasal infections

OTHER

- Fatigue
- Arthralgia
- Sciatica/nerve pain
- Cold hands/feet
- Tendonitis
- Bursitis

PAIN

(please describe below)

OTHER COMMENTS

EMOTIONS AND PREFERENCES

Choose one or two EMOTIONS that seem predominant in your life (frequently experienced, difficult to express, or in some way influential): _____

Please indicate approximate dates and briefly describe the nature of any traumatic experience you have had (e.g., divorce, change of residence, injury, death in family, bankruptcy, etc.):

Date:	Event:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Preference:	Most Liked	Least Liked
Season:	_____	_____
Taste:	_____	_____
Climate:	_____	_____
Time of Day:	_____	_____
Temperature:	_____	_____
Color:	_____	_____

HABITS, DIET, MEDICINES, ALLERGIES

Name: _____ Date _____

LAST PHYSICAL: Date _____ Practitioner: _____ Results: _____

HABITS: Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy Moderate Light None

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coffee: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tea: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exercise: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleep: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Appetite: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Energy: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medication: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vitamins: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diet: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teeth problems: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drugs: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Salt: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stress: _____ |

(Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when.

MEDICINES taken within the last two months (include vitamins, over-the counter drugs, herbs)

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.)
