Alexandra Davis, L.Ac

Patient Health History Questionnaire

Name: _____ Date: _____/_____/_____

(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____

Phone Number: _____

Email address:_____

Home address :

_____

(This information is only used when herbs are ordered for you to be delivered by a local Chinese herb dispensary)

Emergency Contact:_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. *Important*: Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

Height: _____ Weight: _____ lbs.

1. Please identify the chief health concerns that have brought you to seek treatment, listed in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

d. _____ _____

How does this condition affect you? _____

2. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

3. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

4. Do you have any infectious diseases? Y N If yes, please identify: _____

5. Notable Childhood Illnesses: _____

6. **Family History:**

Check those applicable:

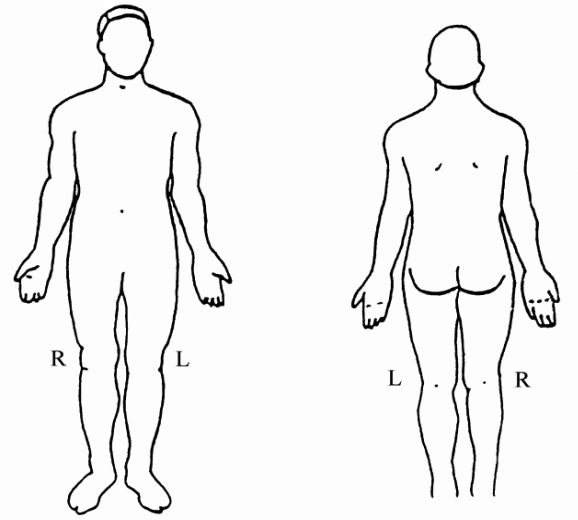
	Father	Mother	Siblings		Father	Mother	Siblings
Cancer	_____	_____	_____	Stroke	_____	_____	_____
Diabetes	_____	_____	_____	Mental Illness	_____	_____	_____
Heart Disease	_____	_____	_____	Asthma/Hay fever/Hives	_____	_____	_____
High Blood Pressure	_____	_____	_____	Kidney Disease	_____	_____	_____

7. **Hospitalizations and Surgeries:**

Reason	When
_____	
_____	
_____	

8. **Musculoskeletal:**

Please circle any areas of pain



Is the pain (please circle) **:**

Sharp	Burning	Aching
Cramping	Dull	Moving
Fixed	Shooting	Electrical
Tingling	Numb	Other:_____

Do the following improve the pain?

Pressure	Cold	Heat
Exercise	Rest	Other_____

Do the following worsen the pain?

Pressure Cold Heat

Exercise Rest Other:_____

Please list any diagnoses you have received for musculoskeletal issues:

Diagnosis When

_____

_____

_____

_____

9. **Systems** (Please circle any that apply)

Emotional

Mood Swings Anxiety Depression Insomnia Irritability Other_____

Head, Eye, Ear, Nose, and Throat

Impaired Vision Eye Pain/Strain Glaucoma Poor night vision Eye Dryness

Impaired Hearing Ear Ringing Ear aches/infections Headaches

Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever Sinus Problems

Respiratory

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Shortness of Breath Asthma Bronchitis

Other: _____

Cardiovascular

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Pacemaker

Palpitations/Fluttering Stroke Heart Murmurs Varicose Veins

Neurologic

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other

Anemia Cancer Rashes Eczema/Hives

Is there anything else I should know?

_____

10. **Lifestyle:**

Do you typically eat at least three meals per day? Y N If no, how many? _____

Exercise routine: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Occupation: _____ Hours/Week: _____ Do you enjoy work? Y/N

11. **Reproductive**

MEN ONLY circle any that you experience:

Swollen testes Testicular pain Impotence Premature ejaculation

Feeling of coldness or numbness in external genitalia Prostate issues Other_____

WOMEN ONLY:

Regular menstrual cycle? Y N Pregnant? Y N

Number of children: _____ Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause (if applicable): _____

Average number of days of flow: _____ Average number of days of entire cycle: _____

Vaginal discharge? Y N Bleeding or spotting between periods? Y N

Do you experience any of the following pre-menstrual syndromes?

nausea vomiting water retention breast swelling

food cravings headaches migraines breast tenderness

depression irritability anxiety other emotions:_____

dull pain, where?_____ sharp pain, where?_____

On a scale of 1-10, how intense are your pre-menstrual symptoms? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (light, normal, heavy)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Nausea (check if yes)							
Other							

12. **Symptomology:**

This section: Follow-up Re-exams Only. Mark box to the left of original if symptom is still experienced.	**Please check the following that currently pertain to you: (Initial Visit: Fill in the section below using the right-most column of boxes. The boxes to the left are for follow-up re-exams).**

↓ ↓

Temperature

							Cold hands
							Cold fingers
							Cold toes
							Cold feet
							Sweaty hands
							Sweaty feet
							Hot body temperature (sensation)
							Cold body temperature (sensation)
							Afternoon flushes
							Night sweats
							Heat in the hands, feet, and chest
							Hot flashes any time of the day
							Thirsty
							Perspire easily
							Lack of perspiration

Overall energy:

							Shortness of breath
							Difficulty keeping eyes open in the daytime
							General weakness
							Easily catch colds
							Low energy
							Feel worse after exercise

Blood function:

							Dizziness
							See floating black spots
							Difficulty falling asleep

Heart function:

							Palpitations
							Anxiety
							Sores on the tip of the tongue
							Restlessness
							Mental confusion
							Chest pain traveling to shoulder
							Frequent dreams
							Wake unrefreshed
							Drink coffee (# of cups per week: _____)

Lung function:

							Nasal Discharge (Color: _____)
							Cough
							Nose Bleeds
							Sinus Congestion
							Dry mouth
							Dry throat
							Dry Nose
							Dry Skin
							Allergies (To what? _____)
							Alternating fever and chills
							Sneezing
							Headache (Location: _____)
							Overall achy feeling in the body
							Stiff neck
							Stiff shoulders
							Sore throat
							Difficulty breathing
							Smoke cigarettes (# of cigarettes per day: _____)
							Sadness
							Melancholy

Spleen function:

							Low appetite
							Abrupt weight gain
							Abrupt weight loss
							Abdominal bloating
							Abdominal gas
							Gurgling noise in the stomach
							Fatigue after eating
							Prolapsed organs (previously diagnosed, which organ? _____)
							Easily bruised
							Hemorrhoids
							Pensive
							Over-thinking
							Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

							Loose
							Constipated
							Incomplete
							Diarrhea
							Blood in stools
							Mucous in stools
							Undigested food in stools

Dampness:

							General sensation of heaviness in the body
							Mental heaviness
							Mental sluggishness
							Mental fogginess
							Swollen hands
							Swollen feet
							Swollen joints
							Chest congestion
							Nausea
							Snoring

Stomach function:

							Burning sensation after eating
							Large appetite
							Bad breath
							Mouth (canker) sores
							Bleeding, swollen or painful gums
							Heartburn
							Acid regurgitation
							Ulcer (diagnosed)
							Belching
							Hicupps
							Stomach pain
							Vomiting

Liver/Gallbladder function:

							Alternating diarrhea and constipation
							Chest pain
							Tight sensation in the chest
							Bitter taste in the mouth
							Anger easily
							Frustration
							Depression
							Irritability
							Frequently unable to adapt to stress (What causes the stress? _____)
							Skin rashes
							Headache at the top of the head
							Tingling sensation
							Numbness
							Muscle spasms
							Muscle twitching
							Muscle cramping
							Seizures
							Convulsions
							Lump in the throat
							Neck tension
							Limited Range-of-Motion, Neck

							Shoulder tension
							Limited Range-of-Motion, Shoulder
							Drink alcohol (What type?_____, How much per week?_____)
							Hip pain
							Recreational drugs (Which? _____, How much per week? _____)
							High-pitched ringing in the ears
							Gall stones (history or current)
							Sexually transmitted disease (Which? _____)

Eyes:

							Itchy
							Bloodshot
							Hot
							Dry
							Watery
							Gritty
							Blurry vision
							Decreased night vision

Kidney and Bladder function:

							Frequent cavities
							Easily broken bones
							Sore knees
							Weak knees
							Cold sensation in the knees
							Low back pain
							Memory problems
							Excessive hair loss

							Low-pitched ringing in the ears
							Kidney stones
							Bladder infections
							Wake during the night twice or more to urinate
							Lack of bladder control
							Fear
							Easily startled

Urination:

							Dark yellow
							Clear and Abundant
							Reddish
							Cloudy
							Scanty
							Profuse
							Strong odor
							Burning
							Painful
							Discharge
							Difficult
							Urgent
							Frequent

Libido (Sex drive):

							High
							Low