Vital Energy
ACUPUNCTURE

HEALTH QUESTIONAIRE

Name: _____ Date: _____

Address: _____

City: _____ Prov.: _____ P-Code: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Referred by: _____ Occupation: _____

Physician: _____ Phone: _____

Address: _____ City: _____ Prov.: _____ P-Code: _____

In Emergency Notify: _____ Phone: _____

Please describe your Main Complaint (symptoms, duration, prior treatments, etc.)

Allergies and Environmental Exposures (food, plant, chemical, metal, drugs, etc.)

Significant Trauma (physical or emotional)

Surgeries (date)

Current Medications (dosages and names of product)

Excercise (days/wk) Type of Exercise Duration of Workout

Diet (Meals/day) Time of meals Snacks (per day) Alcohol (drinks/wk) Caffeinne (drinks/day)

What Vitamins, Supplements, or Herbs have you taken? What results?

What makes your condition(s) better? (movement, sleep, heat, cold, eating, meditation, etc.)

What makes your condition(s) worse? (stress, rainy days, foods, hunger, tired, heat, etc.)

Detailed History

Please check any existing conditions or symptoms you have now

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerance
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis/IBS
- ☐ *Raynaud's Disease*
- ☐ Respiratory All ergies
- ☐ Impotence
- ☐ Emphysema

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- ☐ Seizures ___
- ☐ Allergies ___
- ☐ Heart Disease ___
- ☐ Cancer ___
- ☐ Diabetes ___
- ☐ High Blood Pressure ___
- ☐ Stroke ___
- ☐ Asthma ___
- ☐ Other_____

Please check ✓ if you have had any of these items listed below in the last year
Put a star ★ on the box if you had this in the prior to 1 year ago but do not currently have.

General

- ☐ Poor Sleeping
- ☐ Chills
- ☐ Fevers
- ☐ Bleed/Bruise easily
- ☐ Muscle fatigue/weakness
- ☐ Night Sweats
- ☐ Poor Appetite
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst
- ☐ Cravings
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems
- ☐ Lack of thirst

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Bloating/Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Gas
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Acid reflux/GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal pain
- ☐ Loose stools (>2 per day)
- ☐ Hernia
- ☐ IBS / Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite

Genito-Urinary

- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Night Urination: What Time?_____ How Often?_____
- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Sores on genitals
- ☐ Decreased libido
- ☐ Pain in testicles
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Prostatitis
- ☐ Herpes
- ☐ Urgent urination
- ☐ Copious fl ow
- ☐ Burning urination
- ☐ Dribbling after urination
- ☐ Infections
- ☐ Excessive libido

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Production of phlegm (amount/colour)_____
- ☐ Bronchitis
- ☐ Difficult inhale/exhale

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Detailed History Contued

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats/colds
- ☐ Dental problems
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Musculoskeletal

- ☐ Neck pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Back pain Low___ Middle___ Upper___
- ☐ Soreness/weakness in lower body (back, knee, hip, ankle, foot)
- ☐ Shoulder pain
- ☐ Sprains/Strains
- ☐ Muscle pain
- ☐ Hand/wrist pain
- ☐ Sciatica
- ☐ Muscle weakness
- ☐ Bursitis
- ☐ Carpal Tunnel
- ☐ Foot/ankle pain
- ☐ Tendonitis
- ☐ Rotator Cuff

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal Infect ion
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing
- ☐ Weak or ridged nails

Gynecological/Reproductive

- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Difficult/Painful intercourse
- ☐ Infertility
- ☐ Irregular menstruation
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Fibrocystic breast tissue
- ☐ Polycystic Ovarian Disease
- ☐ PMS
- ☐ Painful menstruation
- ☐ Age of first menses_____
- ☐ Date of last menses_____
- ☐ Date of last PAP/Pelvic_____
- ☐ Number of pregnancies_____
- ☐ Number of ectopic pregancies_____
- ☐ Number of live births_____
- ☐ Number of miscarriages_____
- ☐ Number of abortions_____

Do you practice birth control?_____
What type?_____ How long?_____

Neuropsychological

- ☐ Seizures
- ☐ Lack of coordination
- ☐ Anxiety/Panic attacks
- ☐ Nervousness
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Bad temper/irritable
- ☐ ADD/ADHD
- ☐ Vertigo/Dizziness
- ☐ Concussion
- ☐ Easily susceptible to stress
- ☐ Manic Depression
- ☐ Areas of numbness
- ☐ Depression
- ☐ Seasonal Affective Disorder

Have you ever been treated for emotional problems? ☐ Yes ☐ No
Have you ever considered or attempted suicide? ☐ Yes ☐ No
Have you ever been treated for substance abuse? ☐ Yes ☐ No

Comments Please inform me of any other problems you would like to discuss.

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