

KSK Integrative 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 _____ Today's Date _____

Street _____ City _____ State/Zip _____

Cell Phone _____ eMail _____

Appointment reminders by: _____ E-Mail _____ Text / Carrier: _____

Age _____ Date of Birth _____ Male _____ Female _____ Height _____ Weight _____

Marital Status: Married Never Married Widowed Divorced or Separated

Occupation: _____

Referred by: _____

Emergency Contact: _____ Emergency Contact Relation to you: _____

Emergency Contact telephone: _____

Have you ever had Epstein-Barr Virus, Strep Throat, or Mono? Yes No

Have you ever been treated by acupuncture or Oriental medicine before? Yes No

Main Problem you would like us to help you with: _____

How long ago did this 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 help you with: _____

Past Personal Medical History of Significant Illnesses: Asthma Allergies Diabetes
 Cancer Stroke Heart disease High Blood Pressure Seizures Hepatitis
 Rheumatic Fever Thyroid disease Venereal disease Other: _____

Hospitalizations/Surgeries (including dates): _____

Significant Trauma (auto accidents, falls, etc.): _____

Allergies (drugs, chemicals, metals, foods): _____

Family Medical History: (check all that are applicable) Asthma Allergies Diabetes
 Cancer Stroke Heart disease High Blood Pressure Seizures Thyroid
 Hepatitis Rheumatic Fever Thyroid disease Venereal disease Other: _____

Medicines 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 (e.g. vegetarian, vegan, medical related, or other)?
 No Yes If Yes, what type of diet? _____

Describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you smoke? No Yes If Yes, how many cigarettes or cigars per day? _____

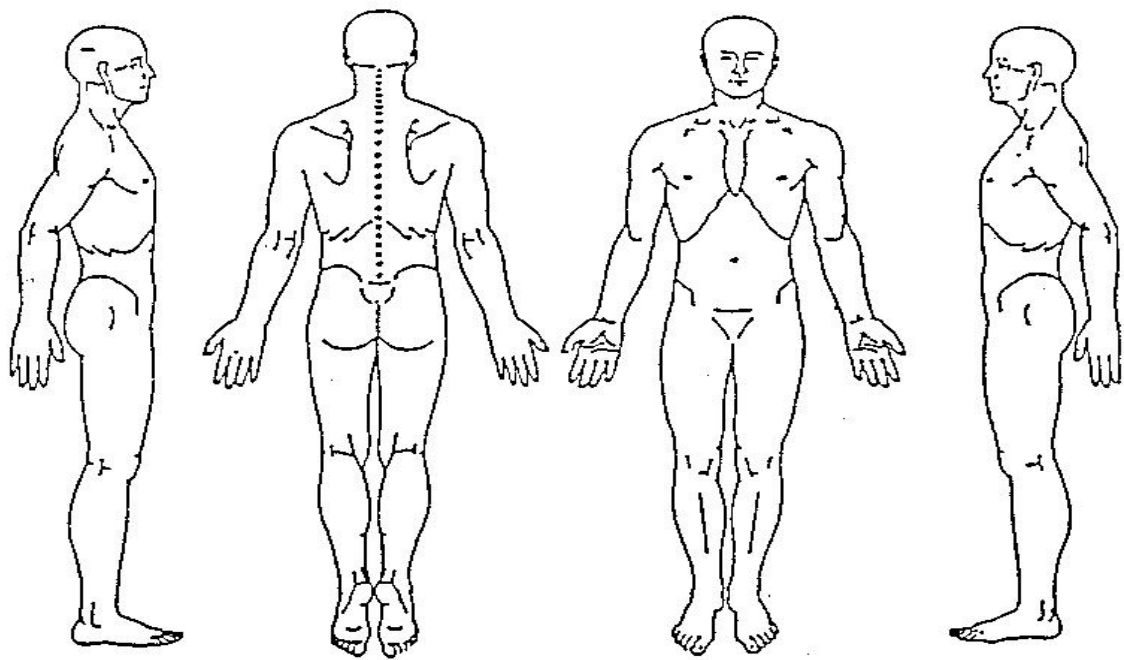
How many cups of caffeinated coffee, tea, or cola do you drink per week? _____

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

How many alcoholic beverages do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

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
- Change in appetite
- Strong thirst for: Hot drinks Cold drinks
- Sudden energy drop, if so what time of day? _____
- Bleed or bruise easily
- Peculiar tastes or smells

SKIN & HAIR:

- Rashes
- Eczema
- Recent moles
- Change in hair or skin texture
- Any other skin or hair problems? _____
- Ulcerations
- Pimples
- Psoriasis

- Hives
- Dandruff
- Dermatitis
- Itching
- Loss of hair
- Acne

HEAD, EYES, EARS, NOSE & THROAT:

- Dizziness
- Eye strain
- Color blindness
- Ringing in ears
- Nose bleeds
- Facial pain
- Headaches, where and when? _____
- Any other head or neck problems? _____
- Concussions
- Eye pain
- Cataracts
- Spots in front of eyes
- Recurrent sore throats
- Sores on lips or tongue

- Migraines
- Poor vision
- Blurry vision
- Poor hearing
- Grinding teeth
- Teeth problems
- Glasses
- Night blindness
- Earaches
- Sinus problems
- Clenching jaw
- Jaw clicks

CARDIOVASCULAR:

- High blood pressure
- Irregular heart beat
- Cold hands or feet
- Varicose or spider veins
- Any other heart or blood vessel problems? _____
- Low blood pressure
- Difficulty in breathing
- Swelling of hands
- Palpitations

- Chest pain
- Blood clots
- Swelling of feet
- Palpitations at rest
- Fainting
- Phlebitis

RESPIRATORY:

- Cough
- Pneumonia
- Difficulty breathing when lying down
- Phlegm production, what color? _____
- Coughing blood
- Pain with deep breath

- Asthma
- Chest tightness
- Bronchitis

GASTROINTESTINAL:

- Nausea
- Gas
- Indigestion
- Bleeding gums
- Hernia
- Colitis
- Chronic laxative use
- Any other problem with Stomach or intestines _____
- Vomiting
- Belching
- Bad breath
- Food stagnation
- Excessive appetite
- Slow digestion

- Diarrhea
- Black stools
- Rectal pain
- Bloating/edema
- Poor appetite
- Abdominal pain/cramps
- Loose stools, more than 2 per day
- Constipation
- Blood in stools
- Hemorrhoids
- Acid reflux/GERD
- IBS/Crohn's disease

GENITO-URINARY:

- Frequent urination
- Urgency to urinate
- Decrease in flow
- 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? _____
- Blood in urine
- Unable to hold urine
- Impotency

- Pain upon urination
- Kidney stones
- Sores on genitals

Men only section:

Date of last prostate checkup _____ PSA results _____

Manual prostate exam results _____

Lab results _____

Related symptoms:

- Prostate problems Delayed stream Dribbling Incontinence
- Rectal dysfunction Increased libido Decreased libido Premature ejaculation
- Back pain Groin pain Testicular pain

REPRODUCTIVE & GYNECOLOGIC:

Women only section:

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. Use back of sheet if more space needed.*
