Silver Moon Acupuncture & Wellness
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HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

E-mail: _____

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

Referred by: _____ Occupation: _____

In Emergency Notify: _____ Phone: _____

Main Complaint (symptoms, diagnosis, duration, etc.): _____

_____

_____

_____

_____

_____

Secondary Complaint (symptoms, diagnosis, duration, etc.): _____

_____

_____

_____

What makes you condition better? (rest, movement, heat, cold, fresh air, eating, etc.): _____

_____

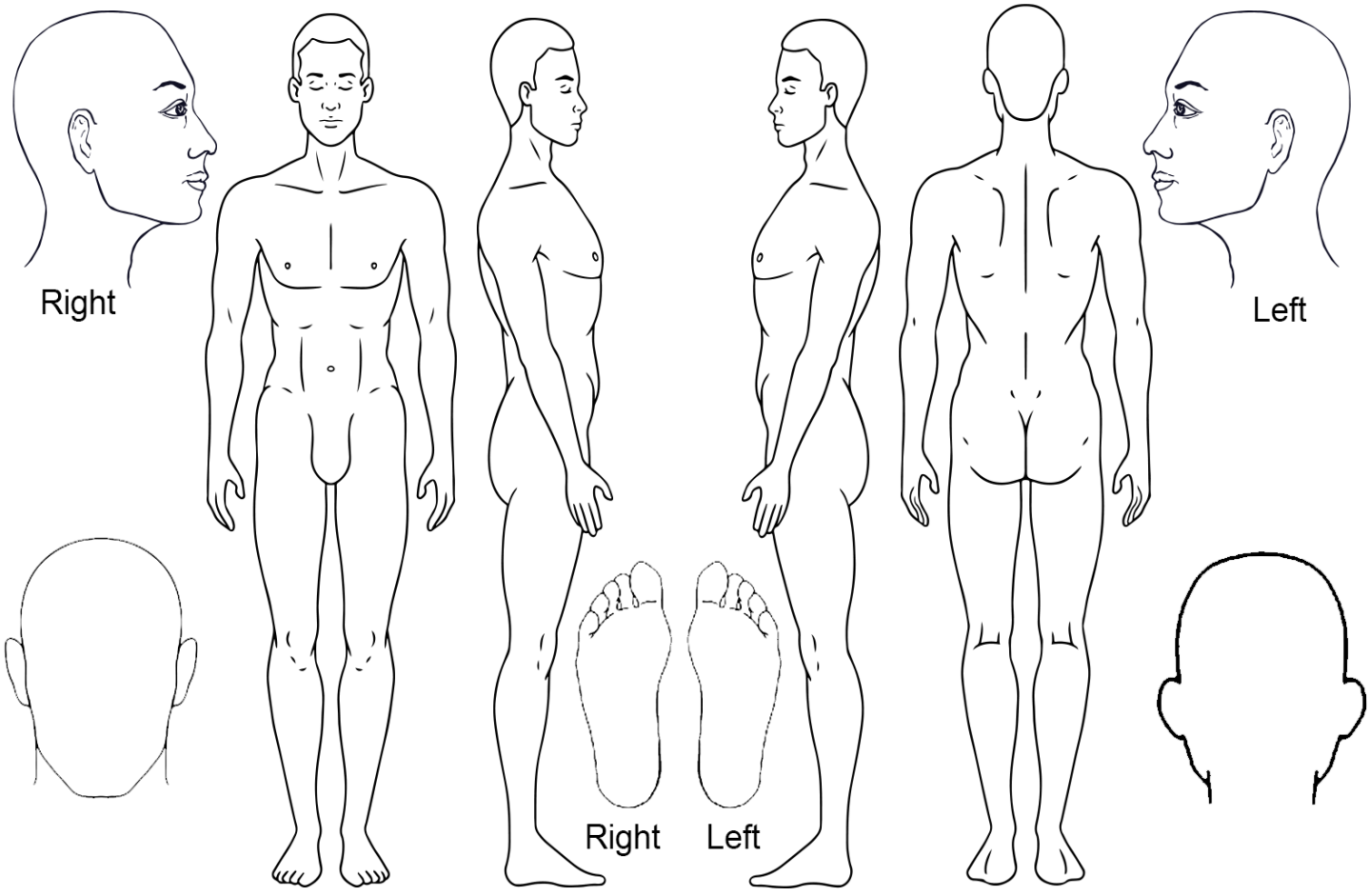
_____

What makes your condition worse? (stress, fatigue, heat, certain food, damp days, etc.): _____

_____

_____

Please Mark Painful or Distressed Areas on the Chart Below



Significant Trauma (physical or emotional): _____

_____

Surgeries (please include date of procedures): _____

_____

Allergies (chemical, environmental, food, drugs, etc.): _____

_____

Medications (names & dosages) Please attach an additional page if necessary: _____

_____

Vitamins/Supplements/Herbs: _____

_____

Exercise:
Days per week Length of Workout Type of Activity

_____

Diet:
Meals per day Snacks Caffeinated Drinks Alcohol per Week

_____

Personal History: Please check any conditions or symptoms you have now.

Cancer: Where? _____ When? _____ Treatment: Chemo/Radiation/Surgery/Other _____
Thyroid Imbalance Alcoholism Addiction Lyme disease

Energy/Sleep
Poor Sleeping Fatigue Sudden energy drop Night Sweats
Excessive Dreams Cannot fall asleep Wake easily

Skin/Hair
Rashes Ulcerations Hives/Allergic Dermatitis Itching Acne
Eczema/Psoriasis Dandruff Loss of Hair Recent Moles
Skin discoloration Change in skin/hair texture Face flushing Dermatitis
Warts Fungal Infection Weak or ridged nail Sweats Easily

Head/Eyes/Ears/Nose/Throat
Dizziness Difficulty swallowing Migraines Glasses Respiratory Allergies Eye Strain
Eye Pain Poor vision Night Blindness Cataracts Color Blindness Blurred vision
Earaches Ringing in Ears Poor hearing Spots in front of eyes Sinus problems
Nose bleeds Recurrent sore throats/colds Grinding Teeth Facial Pain
Headaches Sores on lips/tongue Dental problems Jaw clicks/locks

Cardiovascular
Chest pain or pressure Irregular heart beat Palpitations at rest Fainting
Cold hands/feet Swelling of hands/feet Blood clots Phlebitis Shortness of breath

Varicose/spider veins Pressure in chest High BP Low BP Stroke Dizziness
Spontaneous sweating Raynaud's Disease Anemia Bleed/bruise easily Heart Attack

Respiratory

Cough/Wheezing Coughing blood Asthma Bronchitis Pneumonia
Pain with deep inhalation Tight section in throat Difficult inhale/exhale Emphysema
Difficult breathing when lying down Production of phlegm…what color? _____

Gastrointestinal

Nausea Vomiting Diarrhea Constipation Gas
Belching Black stools Blood in stools Indigestion Bad breath
Rectal pain Hemorrhoids Bloating/Edema Chronic laxative use
Loose stools (>2 per day) Abdominal pain/cramps Changes in appetite
Acid reflux/GERD Hernia Poor appetite Excessive appetite Significant thirst
IBS/Crohn's Disease Ulcerative Colitis Food Allergies/Intolerance
Diabete Liver/Gallbladder Disease Gastritis/Pancreatitis Cravings
Weight loss/gain Hypo/Hyperglycemia Hepatitis Strong thirst (for hot or cold drinks)

Genito-Urinary

Difficult/Painful intercourse Ovarian cysts Age of first menses _____
Vaginal dryness Endometriosis Date of last menses _____
Vaginal sore Uterine Fibroids Date of last PAP/Pelvic _____
Vaginal discharge Fibrocystic breast tissue Number of pregnancies _____
Infertility Polycystic Ovarian Disease Number of live births _____
Irregular menstruation PMS Number of abortions _____
Painful menstruation

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

Musculoskeletal

Neck pain Shoulder pain Hand/wrist pain Carpal Tunnel Knee pain
Sprains/Strains Sciatica Foot/ankle pain Hip pain Muscle pain
Muscle weakness Tendonitis Back pain Low____ Middle_____Upper_____ Bursitis
Rotator Cuff Chronic Pain Condition Muscle weakness/fatigue Arthritis

Neuropsychological

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

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