MARGUERITE DINKINS, L.Ac.

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Health History Questionnaire

Date _____ Name _____
Preferred Phone(s) _____
Preferred Email _____
Address _____City _____State _____Zip _____
Age _____Date of Birth _____Place of Birth _____
Height _____Weight _____Marital Status _____SS# _____
Employer Name & Address _____
Family Physician _____Referred by _____
Emergency Contact _____ Phone _____
Have you been treated by Acupuncture or Chinese Medicine before? Yes ____No____
Have you been treated by Manipulation before? Yes ____No____

Main Problem(s) you would like help with _____
_____
How long ago did this problem begin (be specific)?_____
_____
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?
_____
Have you been given a diagnosis for this problem? If so, what? _____
_____
What kinds of treatment have you tried? _____
_____
_____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____
High Blood Pressure _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____
Seizures _____ Venereal Disease _____ HIV/AIDS _____ Other _____
Surgeries (type of and date) _____
_____
Significant Trauma (auto accidents, falls, etc.) _____
_____
_____
_____
Significant Dental Work (type and date) _____
Birth History (prolonged labor, forceps delivery, etc.) _____
Allergies (drugs, chemicals, foods/result) _____
Family Medical History (check) Diabetes Cancer High Blood Pressure Heart Disease
Stroke Seizures Asthma Allergies Other _____
Medicines taken within the last two months (vitamins, drugs, herbs, etc.) _____
_____
_____
Occupational Stress (physical, chemical, psychological, etc.) _____
_____
Do you have a regular exercise program? Yes No Please Describe _____
_____

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Have you ever been on a restricted diet? Yes No What kind? _____

_____

Please describe you average daily diet:
Morning _____
Afternoon _____
Evening _____
How many packs of cigarettes do you smoke per day? _____
How much coffee, tea, or cola do you drink per day? _____
How much alcohol do you drink per week? _____
Please describe any use of drugs for non-medical purposes _____

Please check any you have had in the last three months:

General
[ ] Poor appetite
[ ] Fevers
[ ] Sweat easily
[ ] Localized weakness
[ ] Peculiar tastes or smells
[ ] Strong thirst (cold or hot?)
[ ] Thirst, no desire to drink
[ ] Sudden energy drop – what time of day?
_____
[ ] Poor sleep
[ ] Chills
[ ] Tremors
[ ] Poor balance
[ ] Fatigue
[ ] Night sweats
[ ] Cravings
[ ] Change in appetite
[ ] Weight gain
[ ] Weight loss

Skin and Hair
[ ] Rashes
[ ] Itching
[ ] Dandruff
[ ] Change in hair or skin
[ ] Ulcerations
[ ] Eczema
[ ] Loss of Hair
[ ] Hives
[ ] Pimples
[ ] Recent moles
[ ] Other _____

Head, Eyes, Ears, Nose, and Throat
[ ] Dizziness
[ ] Glasses
[ ] Poor vision
[ ] Cataracts
[ ] Ringing in ears
[ ] Sinus problems
[ ] Grinding teeth
[ ] Teeth problems
[ ] Concussions
[ ] Eye strain
[ ] Night blindness
[ ] Blurry vision
[ ] Poor hearing
[ ] Nose bleeds
[ ] Facial pain
[ ] Jaw clicks
[ ] Migraines
[ ] Eye pain
[ ] Color blindness
[ ] Earaches
[ ] Spots in front of eyes
[ ] Recurrent sore throats
[ ] Sores on lips or tongue
[ ] Headaches – where and when _____
_____
[ ] Other _____

Cardiovascular
[ ] High blood pressure
[ ] Irregular heartbeat
[ ] Cold hands or feet
[ ] Blood clots
[ ] Low blood pressure
[ ] Dizziness
[ ] Swelling of hands
[ ] Phlebitis
[ ] Chest pain
[ ] Fainting
[ ] Swelling of feet
[ ] Difficulty in breathing
[ ] Other _____

Respiratory
[ ] Cough
[ ] Bronchitis
[ ] Difficulty breathing when lying down
[ ] Production of phlegm - what color? _____
[ ] Coughing blood
[ ] Pneumonia
[ ] Asthma
[ ] Pain with a deep breath
[ ] Other _____

Gastrointestinal
[ ] Nausea
[ ] Constipation
[ ] Black stools
[ ] Bad breath
[ ] Abdominal pain or cramps
[ ] Chronic laxative use
[ ] Vomiting
[ ] Gas
[ ] Blood in stools
[ ] Rectal pain
[ ] Diarrhea
[ ] Belching
[ ] Indigestion
[ ] Hemorrhoids
[ ] Other _____

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Genito-urinary
[ ] Pain on urination
[ ] Urgency to urinate
[ ] Frequent urination
[ ] Unable to hold urine
[ ] Impotency
[ ] Blood in urine
[ ] Kidney stones
[ ] Sores on genitals
[ ] Other _____
Do you wake up to urinate?
[ ] Yes [ ] No
How often?
_____
Any particular color to your urine? _____

Pregnancy and Gynecology
Number of pregnancies ___
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
[ ] Unusual character (heavy or light)
[ ] Painful periods
[ ] Vaginal discharge
[ ] Changes in body/psyche prior to menstruation
[ ] Clots
[ ] Vaginal sores
[ ] Irregular periods
[ ] Last Pap
_____
[ ] Breast lumps
Do you practice regular birth control? [ ] Yes [ ] No
What type and for how long?
_____
[ ] Other
_____

Musculoskeletal
[ ] Neck pain
[ ] Back pain
[ ] Hand/wrist pain
[ ] Muscle pain
[ ] Muscle weakness
[ ] Shoulder pain
[ ] Knee pain
[ ] Foot/ankle pain
[ ] Hip pain
[ ] Other _____

Neuropsychological
[ ] Seizures
[ ] Areas of numbness
[ ] Concussion
[ ] Bad temper
[ ] Lack of coordination
[ ] Depression
[ ] Easily susceptible to stress
[ ] Loss of balance
[ ] Poor memory
[ ] Anxiety
[ ] Other _____

Please note the severity of your problem now:

[_____]

No Problem Worst Imaginable

Please note the severity of your problem within the last week:

[_____]

No Problem Worst Imaginable

Please indicate painful or distressed areas with 1-3 X marks depending on severity:

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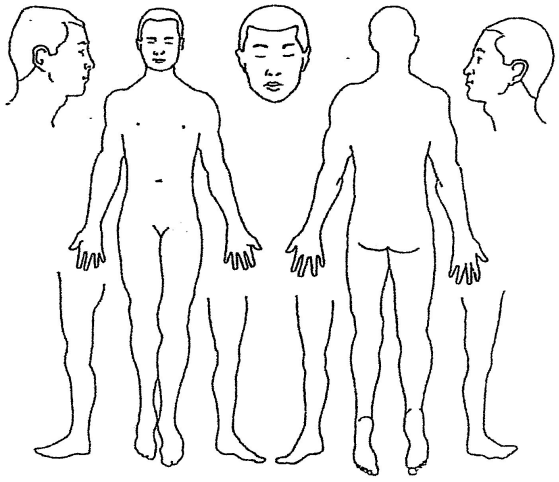

Comments (please mention any other problems you would like to discuss)_____

_____

_____