420 Lancaster Pk, Circleville, OH 43113
P (740) 477-3333 • F (740) 477-1100

Kenneth J. Laux, Jr., DC, DABCA, CCSP ®

HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

1. General Patient Information

Date: ____/____/____

Name: _____

Address:_____

City, State, Postal Code: _____

Phone: (_____)_____

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

Gender: ☐M ☐F

Height: ____'____" Weight: _____lbs.

Occupation: _____ Employer: _____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional: _____

How do these conditions impair your daily activities? _____

_____

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2 Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays: _____

_____

Recent tests: (please indicate test results and date below)

☐Physical	☐Cholesterol	☐Prostate	☐Blood (which?)_____
☐HIV/STD	☐Pap smear	☐Mammography	☐Other : _____

Test Results and Date: _____

Check any you have had in the past:

☐Diabetes	☐Allergies	☐Glaucoma	☐Rheumatic Fever
☐Heart Disease	☐CVA (stroke)	☐Vein condition	☐Thyroid disorder
☐Asthma	☐Pneumonia	☐Tuberculosis	☐Emphysema
☐Jaundice	☐Gonorrhea	☐Mumps	☐Bleeding tendency
☐Syphilis	☐Measles	☐Chicken pox	☐Nervous disorder
☐Meningitis	☐HIV	☐Polio	☐Mononucleosis
☐Epilepsy	☐High fever	☐Hepatitis	☐Multiple Sclerosis
☐Paralysis	☐Cancer	☐Migraines	☐High blood pressure
☐Other lung illnesses	☐other liver illnesses	☐other heart illnesses	☐other kidney illnesses

☐Other: _____

Immunizations: _____

Surgeries: _____

3. Patient Profile

Please mark areas of pain and any scars (please indicate which of the areas are which):

Is the pain:

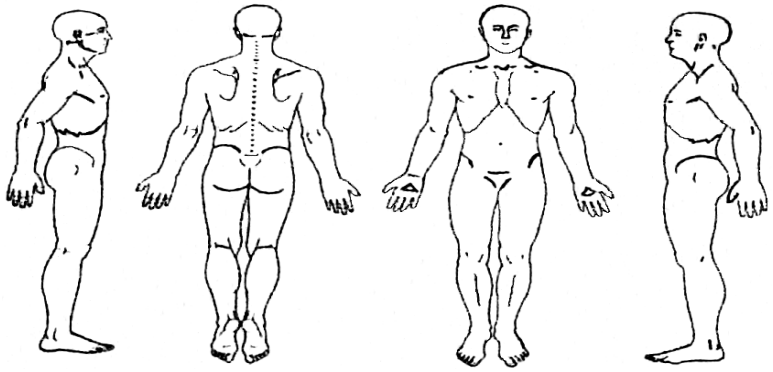
☐Sharp	☐Burning	☐Aching
☐Cramping	☐Dull	☐Moving
☐Fixed	☐Other: _____	

Do the following lessen the pain?

☐Pressure	☐Cold	☐Heat
☐Exercise	☐Other: _____	

Do the following worsen the pain?

☐Pressure	☐Cold
☐Heat	☐Other: _____



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Please check the following that <u>currently</u> pertain to you:

<u>Overall Temperature (Kidney function)</u>:

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

<u>Over all energy (Lung, Kidney function)</u>:

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

<u>Over all blood (Liver, Spleen, Heart function)</u>:

- ☐ Dizziness
- ☐ See floating black spots

<u>Heart function</u>:

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

<u>Lung function</u>:

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

<u>Spleen function</u>:

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

<u>Spleen, Stomach, Large Intestine, Small Intestine function</u>:

- ☐ Loose Stool
- ☐ Incomplete
- ☐ Blood in stools
- ☐ Undigested food in stools
- ☐ Constipated
- ☐ Diarrhea
- ☐ Mucous in stools

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Dampness trapped in the body:

- ☐ 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
- ☐ Heart burn
- ☐ Acid regurgitation
- ☐ Ulcer (diagnosed)
- ☐ Belching
- ☐ Hiccoughs
- ☐ Stomach pain
- ☐ Vomiting

Liver, Gall Bladder 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
- ☐ Recreational drugs (Which? _____, how much per week? _____)
- ☐ High-pitched ringing in the ears
- ☐ Gall stones (history or current)
- ☐ Sexually transmitted disease (Which? _____)

Eyes (Liver function):

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

Kidney, Urinary 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 at night 2x or more to urinate
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

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Urination:

□Normal color □Dark yellow □Clear □Reddish □Cloudy
□Scanty □Profuse □Strong odor □Burning □Painful
□Discharge □Difficult □Urgent □Frequent

Libido: □Normal □High □Low

Women only:

Pregnant? □Y □N Regular menstrual cycle? □Y □N Date of most recent cycle _____

Number of children: _____ Number of pregnancies:_____
Age of first menstruation: _____ Age of menopause: _____
Average # of days of flow: _____ Average # of days of entire cycle: _____
□ Vaginal discharge □ Bleeding between

Do you experience 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? _____

	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 (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

□Swollen testes □Testicular pain □Impotence □Premature ejaculation
□Feeling of coldness/numbness in external genitalia □Other_____

ALL please fill out :

Other Comments: _____

Patient Signature: _____