Qi Holistic Care LLC

Pt. ID #_____

Health History Questionnaire

Welcome to our clinic ! Please help us provide you with complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. Thank you !

PATIENT INFORMATION

Today's Date _____

How did you hear about us ?

❑ Friend ❑ Relative ❑ Newspaper ❑ Yellow pages ❑ Health referral

❑ Other, Explain _____

Name (print) _____

Street Address _____ Date of Birth _____

City, State, Zip _____ Sex ❑ M ❑ F Marital Status: _____

Phone (home) _____ Phone (work)_____

Cell Phone _____ Email _____

Occupation _____ Employer _____

In Emergency Notify _____ Relationship _____ Daytime Ph _____

Insurance Carrier _____ Policy # _____

What do you want treated with acupuncture / Chinese herbal therapy / massage? _____

_____

How long have you had this condition? _____ The onset was: ❑ sudden ❑ gradual

What medical diagnosis have you received for this condition ? _____

What kinds of treatment or therapy have you tried for this condition ? _____

FAMILY MEDICAL HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				

Indicate if any blood relatives have or have had any of the listed conditions:

❑ Allergies	❑ Cancer	❑ Heart disease	❑ Psychological disorders
❑ Arthritis	❑ Chemical dependency	❑ High blood pressure	❑ Seizures
❑ Asthma	❑ Diabetes	❑ Kidney disease	❑ Stroke

❑ Other _____

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PERSONAL HISTORY

Hospitalizations

Year Reason

Pregnancy History

Year Complications, if any

_____

_____

_____

_____

Are you currently pregnant ? ❑ Yes ❑ No

Describe any serious injuries or accidents _____

_____

List any drugs you are allergic to _____

Health Habits: Indicate which substances you use and describe how much you use

❑ Beer _____ ❑ Tobacco _____

❑ Other alcohol _____ ❑ Non-medical drugs _____

Occupational Concerns: *(Indicate if your work exposes you to the following)*

❑ Stress ❑ Hazardous substances ❑ Heavy lifting

Any other that you believe significant, explain _____

SYMPTOM REVIEW *Please indicate if you have experienced any of the following in the last three months:*

Head and Face
- ❑ Headaches
- ❑ Dizziness
- ❑ Memory loss
- ❑ Facial pain

Eyes
- ❑ Blurred vision
- ❑ Eyelid problem
- ❑ Pain
- ❑ Night blindness
- ❑ Cataracts

Ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Discharges
- ❑ Ringing

Nose
- ❑ Frequent colds
- ❑ Sinus trouble
- ❑ Bleeding
- ❑ No sense of smell

Respiration
- ❑ Difficulty inhaling
- ❑ Difficulty exhaling
- ❑ Pain
- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitus
- ❑ Pneumonia
- ❑ Shortness of breath

Heart and Thorax
- ❑ Palpitations
- ❑ High blood pressure
- ❑ Tightness in chest
- ❑ Low blood pressure
- ❑ Difficulty lying flat

Skin
- ❑ Rashes
- ❑ Dryness
- ❑ Moles or lumps that change
- ❑ Excess sweat
- ❑ Night sweat

Urination
- ❑ Frequent
- ❑ Incomplete emptying
- ❑ Painful
- ❑ Unable to hold urine
- ❑ Blood in urine

Neurological
- ❑ Anxiety
- ❑ Tremors
- ❑ Convulsions
- ❑ Numb or tingling limbs
- ❑ Loss of balance
- ❑ Poor coordination
- ❑ Nerve pain

Musculoskeletal
- ❑ Neck pain
- ❑ Muscle pains
- ❑ Knee pain
- ❑ Back pain
- ❑ Muscle weakness
- ❑ Foot / ankle pain
- ❑ Hand / wrist pain
- ❑ Shoulder pain
- ❑ Hip pain

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Mouth
- ❑ Gum problems
- ❑ Teeth problems
- ❑ Tongue problems
- ❑ Lip problems
- ❑ Jaw problems
- ❑ Unusual tastes
- ❑ No sense of taste

Throat
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Circulation
- ❑ Bruise easily
- ❑ Cold limbs
- ❑ Swelling hands or feet

Gastrointestinal
- ❑ Never thirsty
- ❑ Excess appetite
- ❑ Poor appetite
- ❑ Abdominal pain
- ❑ Nausea or vomiting
- ❑ Excess thirst
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoid
- ❑ Indigestion
- ❑ Chronic heartburn
- ❑ Blood in stool

Sleep
- ❑ Insomnia
- ❑ Drowsiness
- ❑ Excess dreaming

Women only
- ❑ Premenstrual pain
- ❑ Painful menses
- ❑ Heavy menstrual flow
- ❑ Light menstrual flow
- ❑ Menstrual clots
- ❑ Irregular menses
- ❑ No menstrual flow
- ❑ Miscarriages
- ❑ Are you still having monthly menstrual periods ?

Men only
- ❑ Penis blood / mucous discharge
- ❑ Impotence
- ❑ Prostatitis

MEDICATION LIST

List medications you are currently taking:

_____

_____

_____

_____

_____

_____

Describe briefly your present medical symptoms and anything else we should know about your health not covered in the above:

_____

_____

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold the practitioner or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature Date

_____

Reviewed by Date