HILL COUNTRY
Healing Haven

Health Questionnaire

Date: / /

Last Name ______________________ First Name __________________________ MI__________

Address ____________________________ City ________________ State _____ Zip __________

Emergency contact Name, Phone & Relationship: ____

Primary Phone Number ________________ Secondary Phone Number__________________

Email Address ___________________________________ DOB / / Age __________

Height: _________Weight: __________ Occupation: ______________ Hours per week: _____

Gender: F / M Married: __ Separated: __ Divorced: __ Widowed: __ Single: __ Partnership: __

Live with: Spouse: __ Partner: __ Parents: __ Children: __ Friends: __ Alone: __ Other: ______

Have you ever had acupuncture before? Where? ____

Your medical doctor's name & phone number: ____

Major Health Complaints

1. ______________________________

2. ______________________________

3. ______________________________

Additional Health Complaints

1. ____________________________

2. ____________________________

3. ____________________________

What initiates your symptoms? ____

What makes them better? ____

What makes them worse? ____

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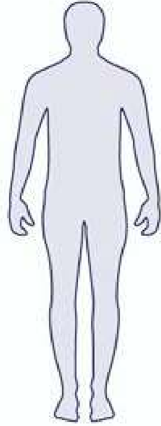
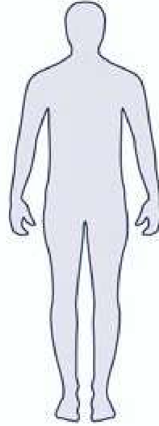
Pain **Please mark the location(s) of your pain on the diagram below**





Location of Pain: ________________________________
Intermittent ________ **Constant**_______________

Better or Worse with:
Pressure ______________________________
Heat __________________________________
Cold __________________________________
Movement _____________________________
Rest __________________________________

Pain Quality:
Fixed _______ **Radiating** _______ **Sharp**_________ **Dull/ache** ________
Burning_____ **Other**____

General Systems/Element overview (check all that apply)

Water Element/Kidney System
___ Cold hands/feet
___ Cold body/aversion to cold
___ Hot body/aversion to heat
___ Night sweating
___ Hot flashes
___ Nighttime urination
___ Frequent urination or urinary difficulty
___ Incontinence
___ Kidney stones
___ Frequent cavities
___ Sensitive, broken or loose teeth
___ Weak bones
___ Weak or sore knees
___ Cold, weak or sore knees
___ Tinnitus
___ Hearing problems
___ Low back pain
___ Hair loss or premature graying
___ Reduced sexual function/
___ Thyroid dysfunction
___ Edema
___ Excessive fear

Metal Element/Lung Function
___ Chronic allergies
___ Easily prone to illness
___ Easily fatigued
___ Nasal/sinus problems
___ Persistent cough
___ Shortness of breath
___ Wheezing
___ Asthma
___ Bronchitis
___ Skin problems
___ Greif/excessively weepy

Fire Element/Heart Function
___ Palpitations (uncomfortable awareness of heartbeat)
___ Rapid heart beat
___ Chest Pain
___ Manic moods
___ Anxiety
___ Insomnia
___ Mental restlessness
___ High blood pressure
___ Restless or vivid dreams
___ Arrhythmia
___ Forgetfulness

___ Dark urine or painful urination
___ Tongue ulcers or gum problems
___ Hot palms and soles

Earth Element/Spleen Function
___ Low or weak appetite
___ Strong food cravings
___ Gas &/or bloating
___ Indigestion
___ Gurgling in the intestines
___ Hypoglycemia
___ Fatigue esp. after meals
___ Weight gain / overweight
___ Weight loss (unintended)
___ Bruise easily
___ Hemorrhoids
___ Muscle weakness
___ Diarrhea/loose stool
___ Excessive worry or obsessive thoughts
___ Diabetes

Earth element/Stomach Function
___ Stomach ache
___ Stomach ulcer
___ Bleeding gums
___ Hiccups
___ Acid reflux
___ Heartburn
___ Nausea
___ Vomiting
___ Ravenous appetite
___ Bad breath (halitosis)
___ Belching
___ Mouth ulcers
___ Eating Disorder

Wood Element/Liver and Gall Bladder Function
___ Irritability
___ Depression
___ Easy to anger
___ Pain in the ribcage
___ General body restlessness or tension
___ Headaches
___ Migraines
___ Dizziness or Vertigo
___ Poor vision/floaters
___ Shingles
___ Herpes simplex
___ Warts
___ Convulsions
___ Spasms or tremors
___ Hepatitis
___ Gallstones
___ Indecisive
___ Fullness below ribs
___ Shoulder/neck tension
___ Insomnia 11pm-3am

Bowel Function and Elimination
___ Loose stools ___ diarrhea
___ Blood in the stool (black tar stool)
___ Constipation
___ Small, hard, dry stool
___ Mucous in the stool
___ IBS or Colitis
___ Chron's Disease
___ Difficult or painful movements

Accumulated Dampness
___ Mental fogginess
___ Swollen hands or feet
___ Mental sluggishness
___ Joint stiffness/ache
___ Heaviness of the head, limbs or body
___ Edema in the legs or whole body
___ Symptoms worse in damp/wet/humid weather

Blood Function
___ Dizziness
___ Tingling in extremities
___ Itchy or dry skin
___ Pale skin or dry skin
___ Pale nail beds, weak or brittle nails
___ Poor night vision
___ Floaters in vision
___ Poor memory
___ Difficulty concentrating
___ Scanty menses
___ Fainting
___ Anemia

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Female Health (if Applicable)

Are you currently pregnant? Yes / NO   Date of Last Period ________________ Age of onset? ___________

Length of Cycle: __________ # Days Bleeding: _________ Flow: _____________ Color: _________________

(please circle yes or no)

Menstrual Pain: Yes / No
Clots: Yes / No
PMS: Yes / No
Yeast Infections: Yes / no

Irritability: Yes / No
Mood Swings: Yes / No
Cravings: Yes / No
Birth Control: Yes / NO
Method:________________

Fatigue: Yes / No
Breast Tenderness: Yes / No
Vaginal Discharge: Yes / No
Nipple Discharge: Yes / No

Number of:
Pregnancies _____ Ectopic _____ Cesarean Births _____ Vaginal Births _____
Abortions _____ Miscarriages _____ Failed IUI _____ Failed IVF's _____

Your Ob/Gyn ____________________________Reproductive Endocrinologist ________________________________

Male Health

(Check all that apply)

__ Reduced sexual energies
__ Groin pain
__ Prostate problems
__ Testicular Pain

__Sexual dysfunction
__ Infertility
__ Premature ejaculation
__ Impotence

__ Pain with urination
__ Seminal emission
__ Hernia
__ Low Testosterone

Family History

Father: ☐ Living Age: ______ Health Status: _____________________
☐ Deceased Age at death: _______ Cause: _________________________
Mother: ☐ Living Age: ______ Health Status: _____________________
☐ Deceased Age at death: _______ Cause: _________________________
Brother(s):☐ Health Status: ____
Sister(s): ☐ Health Status: ____
Children: ☐ Boy(s) # ______ ☐ Girl(s) # ______ Health Status: _______________

Check or circle illnesses that have occurred in any of your blood relatives**:**
☐ Alcoholism ☐ Bleed easily ☐ Diabetes ☐ Heart Disease ☐ Kidney disease ☐ Obesity
☐ Allergy ☐ Cancer ☐ Epilepsy ☐ High blood pressure ☐ Mental illness ☐ Stroke
☐ Other: ____

Personal History

Check or circle any illnesses or conditions you currently have or have had in the past:
☐ AIDS/HIV ☐ Bleed easily ☐ Heart Disease ☐ Multiple sclerosis ☐ Shingles
☐ Alcoholism ☐ Cancer ☐ Hepatitis ☐ Stroke
☐ Allergies ☐ Chicken Pox ☐ High blood pressure ☐ Pertussis/whooping cough ☐ Thyroid disorder
☐ Anemia ☐ Diabetes ☐ Jaundice ☐ Pneumonia ☐ Tuberculosis
☐ Antibiotic Use ☐ Epilepsy ☐ Kidney disease ☐ Polio ☐ Ulcers
☐ Asthma ☐ Glaucoma ☐ Mental/emotional disorder ☐ Rheumatic fever ☐ Vascular disease
☐ Other: ____

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Do you have a PACEMAKER? Yes / No

List surgeries, serious illnesses, broken bones, hospitalizations, etc.: ___________________________________

Allergies: Please list any allergies to Drugs, Food, Etc…____
____

Medications: ____

____

Is there anything else you feel would be pertinent in helping us get a full picture of your health?

OFFICE POLICIES

<u>For All Clinic Appointments:</u>
<u>Arbitration</u> <u>Agreement.</u> By signing this form, you are acknowledging that you read the Arbitration Agreement and are agreeing to have any issue of medical malpractice decided by a neutral arbitration and are giving up your right to a jury or court trial. See Article 1 of Hill Country Community Acupuncture's Arbitration Agreement.

<u>HIPAA Acknowledgement and Office Policies</u>
I acknowledge that I have been provided access to the "Notice of Privacy Practices". I understand that I have the right to review "Notice of Privacy Practices" prior to signing this document.

I understand that staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone. Please let your practitioner know if this is not acceptable.

I __give__ do not give permission to have my acupuncturist contact the referring or primary care physician to discuss care.

I give permission for my acupuncturist to discuss my care with __________________________________.

Hill Country Healing Haven is not in network and does not bill insurance. If you have out of network benefits you can request a superbill to submit to your insurance.

24 hour notice is required when cancelling appointments. If you miss your appointment or less than 24hr notice is given you will be charged for the session.

Patient Signature ____ Date___________________