HILL COUNTRY
Healing Haven

Health Questionnaire

Date: / /

Last Name _____ First Name _____ MI_____

Address _____ City _____ State _____ Zip _____

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: _____

Emergency contact Name, Phone & Relationship: _____

Primary Phone Number _____ Secondary Phone Number_____

Email Address _____

DOB / / Age _____

Major Health Complaints	**Additional Health Complaints**
1. _____	**1.** _____
2. _____	**2.** _____
3. _____	**3.** _____

What initiates your symptoms? _____

What makes them better? _____

What makes them worse? _____

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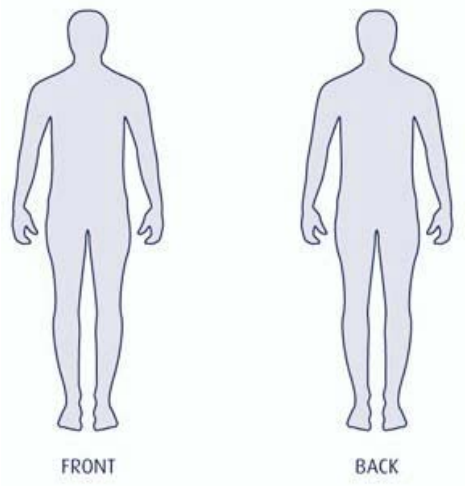
<u>Pain</u> **Please mark the location(s) of your pain on the diagram below**



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: _____

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

For All Clinic Appointments:
Arbitration Agreement. 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.

HIPAA Acknowledgement and Office Policies
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.

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 _____.

I give Hill Country Healing Haven the right to share necessary information with my insurance company in order to submit a claim for reimbursement and collect payments directly (if applicable).

24 hour notice is required when cancelling appointments.

Patient Signature _____ Date_____