Life Seed Acupuncture & Herbal Medicine, PLLC
Christy Ouk, L.Ac., M.Ac.O.M.
East Asian Medicine Practitioner

Health History Questionnaire

Name: ____ Phone: (h) ______________________ (w) __________________

Address: ____ City: ______________ State: _______ Zip: ____________

Email Address: ____ Today's Date: _________________________

Age: _______________ Date of Birth: ___________________ Place of Birth: ____

Height: ________________ Weight: _______________________ Marital Status: ______________________________________

Employer Name & Address: ____

Insurance Company: ____ Policy #: ______________________________

Family Physician: _____________________________________ Referred By: ____

Emergency Contact: ____ Phone: ________________________________

Have You Been Treated By Acupuncture or Oriental Medicine 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, 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 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? _________________________

____

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

____

Please describe your 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 recreational drugs: ____

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 hair or skin problems

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
☐ Ear aches
☐ Spots in front of eyes
☐ Recurrent sore throats
☐ Sores on lips or tongue
☐ Headaches: where & when
____
____

☐ Other head or neck problems
____
____

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 heart or blood vessel problems ______________
____

Respiratory

☐ Cough
☐ Bronchitis
☐ Difficulty in breathing when lying down
☐ Production of phlegm
What color? ____________
☐ Coughing blood
☐ Pneumonia
☐ Asthma
☐ Pain with a deep breath
☐ Other lung problems
____

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 stomach or intestinal problems ______________
____

Genito-urinary

☐ Pain on urination
☐ Urgency to urinate
☐ Frequent urination
☐ Unable to hold urine
☐ Impotence
☐ Blood in urine
☐ Kidney stones
☐ Sores on genitals
☐ Other genital or urinary system problems ________
____

☐ 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 _________________
First day of last menses _____
____

☐ Unusual character (heavy or light)
☐ Painful periods
☐ Vaginal discharge
☐ Changes in body / psyche prior to menstruation
☐ Clots
☐ Vaginal sores
☐ Irregular periods
☐ Last Pap Exam __________
☐ Breast lumps
Do you practice birth control?
☐ Yes ☐ No
What type and for how long?
____

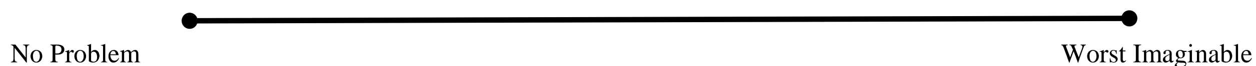
Musculoskeletal

☐ Neck pain
☐ Back pain
☐ Hand / wrist pain
☐ Muscle pain
☐ Muscle weakness
☐ Shoulder pain
☐ Knee pain
☐ Foot / ankle pain
☐ Hip pain

Neuropsychological

☐ Seizures
☐ Areas of numbness
☐ Concussion
☐ Bad temper
☐ Dizziness
☐ Lack of coordination
☐ Depression
☐ Easily susceptible to stress
☐ Loss of balance
☐ Poor memory
☐ Anxiety
☐ Other neurological or psychological problems
____
____

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

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

____

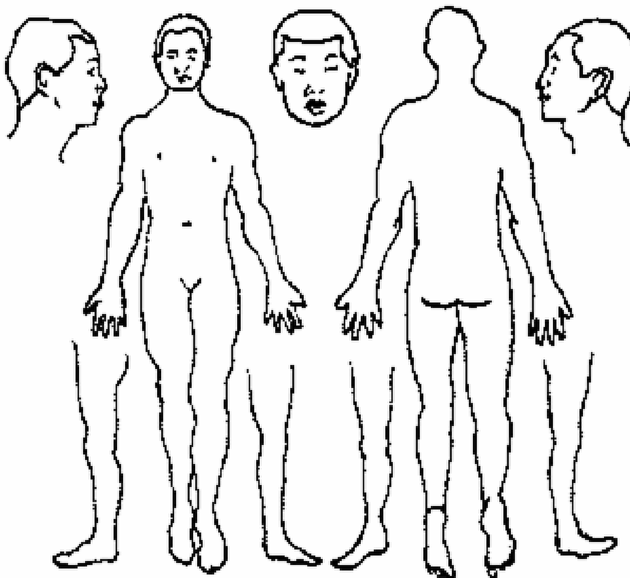
____

____

____

____

Indicate painful or distressed areas:



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