Date: _________, 20___ Denver Acu Pro

Maria Baraybar Lee, Ph.D., L. Ac., Dipl. Ac and TCM
1529 York St. Suite 200, Denver, Co 80206
303-333-9977

Health History Questionnaire

Please help us provide you with a complete evaluation by carefully filling out this questionnaire. All of your responses will be held absolutely confidential. Please add anything else you would like to bring to our attention in the comments section at the end of this form. If you have any additional questions/comments, please ask. Thank you.

Name:		EMAIL address:	
Street:		City/State/Zip:	
Age:	Height:	Weight:	Date of Birth:
Home Phone:		Work/Cell Phone:	
Occupation:		Social Security #:	
Emergency Contact:		Relation:	
Referred By:		Family Physician:	
Insurance Carrier:		Policy #:	
Have you tried Acupuncture or Oriental Medicine before?			

Main problems you would like us to help you with: ____

____

Have you been given a diagnosis for the problem? _______ If so, what?______________________________

____

What kinds of treatment have you tried? ____

Significant Illnesses (please circle): Cancer Diabetes Hepatitis High blood pressure
Heart disease Rheumatic fever Thyroid disease Seizures Autoimmune disease
Venereal disease Celiac Other (Specific autoimmune disease, cancer, etc):

____

Surgeries:____

Significant Trauma (auto accidents, falls, etc) :____

____

Additional Past Medical History (please include dates):

____

____

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Health History Questionnaire (continued)

Birth History (prolonged labor, forceps delivery, etc):____

____

Allergies (drugs, chemicals, foods, etc):____

____

Family Medical History (please circle): Diabetes Cancer Allergies Asthma Stroke

Depression High blood pressure Autoimmune disease Heart disease

Other (Specific, autoimmune disease, cancer, etc.):____

Medicines taken within the last two months:____

____

Occupation:_________________________ Occupational stressors (Chemical, physical, psychological, etc):

____

Do you have a regular exercise program?___________ If so, please describe:_________________________

____

Have you ever been on a restricted diet?____________ If so, what kind?_____________________________

Morning Afternoon Evening Snacks

____

____

____

Do you smoke?___________ How many cigarettes/packs per day?__________________________________

How much alcohol do you drink per day?____

Please describe any use of drugs for non-medicinal purposes:______________________________________

____

Additional Comments (please add any additional comments here, after filling out the rest of the form):

____

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____

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Please Check if you have had within the last 3 months:

Health History Questionnaire (Continued)

General

- ☐ Poor appetite
- ☐ Change in appetite
- ☐ Cravings
- ☐ Strong thirst (hot or cold)
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Sudden energy drop (time of day)__________

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent Moles
- ☐ Change in hair or skin texture
- ☐ Any 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 blind
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

Headaches (where and when)? ____How often?____________

Other head or neck problems: ____

Cardiovascular

- ☐ Dizziness
- ☐ Phlebitis
- ☐ Blood clots
- ☐ Cold hands or feet
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Fainting
- ☐ Angina
- ☐ Swelling of feet
- ☐ Swelling of ankles
- ☐ Difficulty breathing

Other heart or blood vessel problems: ____

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ Difficulty in breathing when lying down
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath

Production of phlegm What color? ____

Other lung problems: ____

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Health History Questionnaire (continued)

Gastrointestinal

☐ Nausea
☐ Constipation
☐ Black stools
☐ Bad breath
☐ Abdominal Pain
☐ Abdominal cramps
☐ Chronic laxative use
☐ Metamucil or stool softener
☐ Vomiting
☐ Gas
☐ Blood in stool
☐ Diarrhea
☐ Belching
☐ Indigestion

Gentio-Urinary

☐ Pain on urination
☐ Urgency to urinate
☐ Decrease in flow
☐ Frequent urination
☐ Unable to hold urine
☐ Impotency
☐ Blood in urine
☐ Kidney stones
☐ Sores on genitals

Do you wake up to urinate? ______ How often? __________

Any other problems with your genital or urinary system? _________________________

Reproductive and gynecologic

☐ Unusual character (heavy or light)
☐ Painful periods
☐ Vaginal discharge
☐ Clots
☐ Vaginal sores
☐ Irregular periods
☐ Breast lumps
☐ Changes in body/psyche prior to menstruation

_ Age at first menses
_ Menopause (Age:____)
_ Number of pregnancies
_ Miscarriages
_ Period between menses
_ Duration
_ Number of births
_ Premature births
_ Abortions

Do you practice birth control? ________ What type, and for how long? ____________________

Musculoskeletal

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

Other joint or bone problems:___________________________

Neuropsychological

☐ Seizures
☐ Concussion
☐ Dizziness
☐ Depression
☐ Anxiety
☐ Areas of numbness
☐ Bad temper
☐ Lack of coordination
☐ Loss of balance
☐ Poor memory
☐ Easily Susceptible to stress

Have you ever been treated for emotional problems? _____________

Have you ever considered or attempted suicide? _________________

Any other neurological or psychological problems? ________________

Denver Acu Pro

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Health History Questionnaire (continued)
Muscles, Joints and Bones

Do you have pain or tightness? Where?____

Pain fees worse with:____

Pain feels better with:____

Current Symptoms:

CHECK CURRENT SYMPTOMS CIRCLE SYMPTOMS that have affected you in the PAST

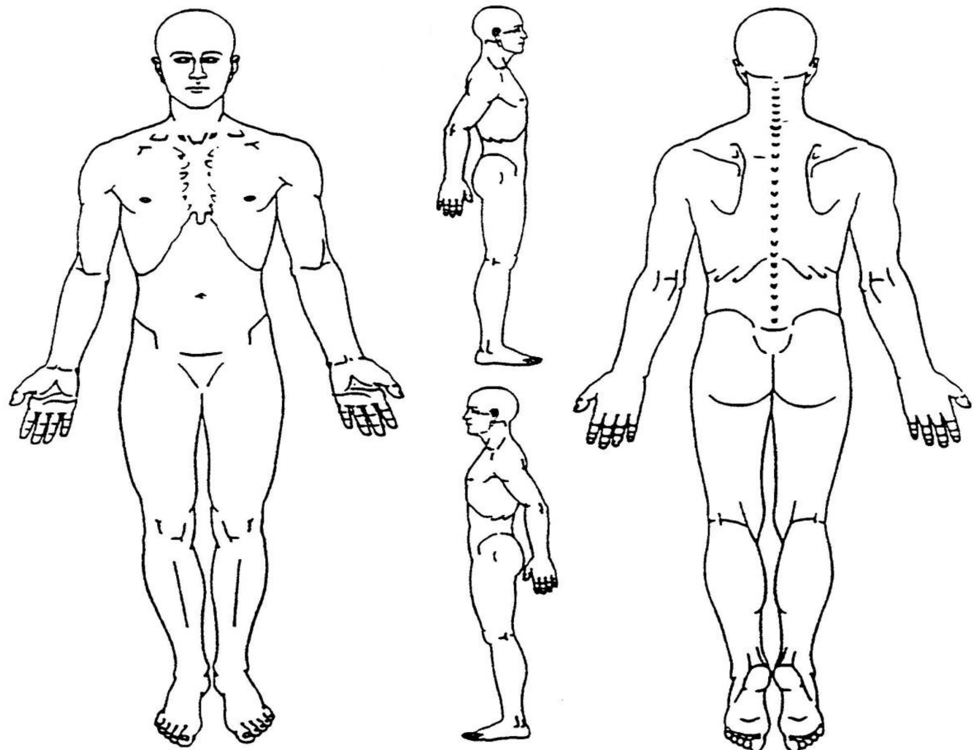
- ☐ Swollen joints
- ☐ Arthritis/joint pain
- ☐ Bone pain
- ☐ Repetitive strain
- ☐ Spinal curvature
- ☐ Tendonitis
- ☐ Rheumatism
- ☐ Muscle cramps/pain
- ☐ Weak muscles
- ☐ Other

The pain feels (check all that apply):

- ☐ Sharp
- ☐ Superficial
- ☐ Tingling
- ☐ Burning
- ☐ Fixed
- ☐ Dull
- ☐ Deep
- ☐ Numb
- ☐ Aching
- ☐ Stiff
- ☐ Moves around
- ☐ Other:_________

On the following diagram, please SHADE in the areas that you would like to address.
KEY: USE LETTERS below to indicate TYPE and LOCATION of discomfort.

A = Ache
B = Burning
P = Pins & Needles
S = Stabbing
N = Numbing
Pls = Pulsing
O = Other



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Notes

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All information on this page is confidential and will not be shared without your permission. Initial ____