Patient Health Questionnaire

Name____ **Date**____________________

Goals: What would you most like to achieve through your work at Essential Points Acupuncture?

1.____

2.____

3.____

4.____

Major Symptoms:

1. What is your chief complaint?_______________________________________
2. When did this begin?____
3. What have you tried ?____
4. What makes it better?____

Medical History: Please check all that apply

□ Arthritis □ Asthma □ Autoimmune Disease □ Cancer □ Diabetes □ Gallstones
□ Hepatitis □ HIV □ High Cholesterol □ High Blood Pressure □ Kidney Stones
□ Rheumatic Fever □ Ruptured Appendix □ Seizures □ Thyroid Disease □ Venereal Disease

Surgical History

Type	Date
1.____	______________
2.____	______________
3.____	______________

Medications/Supplements: Please list all medications that you currently take

Name	Dose	Reason
1.__________________	________________	__________________
2.__________________	________________	__________________
3.__________________	________________	__________________
4.__________________	________________	__________________

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Nutrition

1. Do you follow a special diet (i.e. Vegetarian, Low Carb, etc.)?_________________________

2. What do you eat on a "typical" day?

   a. Breakfast____

   b. Lunch____

   c. Dinner____

   d. Snacks____

3. Food you tend to crave____

4. Food you dislike____

5. How much coffee/tea/soda per day____

Social History

1. How much per day do you use the following?

   a. Alcohol________________________

   b. Cigarettes/cigars__________________

   c. Other Drugs_____________________

2. Have you ever had a problem with alcoholism? ◻ Yes ◻ No

3. Have you ever been dependent on other drugs? ◻ Yes ◻ No

4. If so, which one (s) and when?____

5. Please describe your current exercise regimen:

   Hours per week_________ Activities___________________________________

6. How many hours do you sleep per night during the week? ______________________

7. Do you wake feeling rested? ◻ Yes ◻ No

8. Do you feel you sleep well at night? ◻ Yes ◻ No

9. Have you been treated for emotional issues? ◻ Yes ◻ No

10. Have you ever considered or attempted suicide? ◻ Yes ◻ No

For Women Only

1. Are you pregnant now? ▫ Yes ▫ No ▫ Unsure

2. Number of occurrences:

   Live Births_____ Pregnancies_____ Miscarriages_____ Abortions_____

3. Age of first menses______ Menopause (if applicable)_______

4. Date of last Pap Smear________________ Normal? ▫ Yes ▫ No

5. Date of last Mammogram______________ Normal? ▫ Yes ▫ No

6. Is your cycle regular? ▫ Yes ▫ No Date of Last Menses:_________________

7. Are you on birth control (pill, patch)? ▫ Yes ▫ No

8. Average number of days of flow? _____

9. Flow is: ▫ Normal ▫ Heavy ▫ Light

10. The color is: ▫ Fresh Red ▫ Dark ▫ Purple ▫ Brown ▫ With Clots

11. Do you have the following menstruation related symptoms? (check all that apply)

    ▫ Cramps ▫ Nausea ▫ Breast Distention ▫ Emotional Changes

    ▫ Headache ▫ Other ____

12. Do you have the following general symptoms?

    ▫ Pain with Intercourse ▫ Bleeding Between Periods

    ▫ Vaginal Discharge ▫ Vaginal Odor ▫ Vaginal Dryness

For Men Only

1. Please check all that apply:

   ▫ Erectile Dysfunction ▫ Premature Ejaculation

   ▫ Testicular Swelling/Pain ▫ Enlarged Prostate

   ▫ Prostate Cancer ▫ Other______________________________

2. Do you get up at night to urinate? ▫ Yes ▫ No If so, how often?_____________

3. To what extent do these conditions interfere with your daily activities?

____

4. Have you sought medical intervention for these conditions? ________________________

5. What treatments have you tried & how successful were they?__________________________________

Please check any symptoms you currently have or have had in the past.

General

- ☐ Aversion to cold
- ☐ Fatigue
- ☐ Chills
- ☐ Dizziness
- ☐ Excess thirst
- ☐ Fevers
- ☐ Drowsiness
- ☐ Change in appetite
- ☐ Night sweats
- ☐ Spontaneous sweating
- ☐ Weight loss
- ☐ Weight gain
- ☐ Nervousness
- ☐ Other____________

Head and Neck

- ☐ Blurred vision
- ☐ Heaviness in head
- ☐ Frequent headaches
- ☐ Phlegm in throat
- ☐ Earache
- ☐ Ringing in ears
- ☐ Eye strain
- ☐ Nasal discharge
- ☐ Hearing loss
- ☐ Frequent sore throat
- ☐ Red eyes
- ☐ Floaters in vision
- ☐ Sores in mouth
- ☐ Sinus problems
- ☐ Neck stiffness
- ☐ Enlarged lymph glands
- ☐ Grinding teeth
- ☐ Other_____________

Respiratory

- ☐ Asthma
- ☐ Allergies
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Phlegm production
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling
- ☐ Other____________

Musculoskeletal - Pain, weakness, numbness in:

- ☐ Arms
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Upper back
- ☐ Mid back
- ☐ Lower back
- ☐ Neck
- ☐ Pain in joints
- ☐ Cold limbs
- ☐ Lack of strength

Neurological

- ☐ Tremors
- ☐ Seizures
- ☐ Convulsions
- ☐ Paralysis
- ☐ Recent clumsiness
- ☐ Vertigo
- ☐ Other_____________

Genitourinary

- ☐ Dark urine
- ☐ Diluted/clear urine
- ☐ Profuse urine
- ☐ Scanty urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Urgency to urinate
- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Poor bladder control
- ☐ Other___________

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Varicose veins

Diet & Lifestyle

- ☐ Vegetarian
- ☐ Diet high in meat
- ☐ Diet high in packaged food
- ☐ Diet high in fried food
- ☐ Eat a lot of sweets
- ☐ Smoke cigarettes
- ☐ Drink alcohol regularly
- ☐ Regular use of caffeine
- ☐ Use drugs
- ☐ Take sleep aid
- ☐ Exercise regularly
- ☐ Exercise excessively

Gastrointestinal

- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Poor appetite
- ☐ Difficulty swallowing
- ☐ Stomachache
- ☐ Bloody stools
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/reflux
- ☐ Other______________

Emotional

- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Irritability
- ☐ Crying frequently
- ☐ Fearful
- ☐ Angry
- ☐ Forgetful
- ☐ Cloudy thinking
- ☐ Other___________

Women Only

- ☐ Abnormal pap smear
- ☐ Endometriosis/PCOS
- ☐ History of STD ________
- ☐ Chlamydia
- ☐ Painful periods
- ☐ Pain with ovulation
- ☐ Breast lumps
- ☐ Breast discharge
- ☐ Menopausal
- ☐ Low sexual energy

Men Only

- ☐ Genital pain
- ☐ STD/Sores on genitals
- ☐ Impotence
- ☐ Ejaculation problems
- ☐ Lump in testicles
- ☐ Nocturnal emission
- ☐ Low sexual energy

Family History

Please check all that apply:

Condition	Mother	Father	Sibling	Child	Grandparent
Heart Disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Mental Illness					
Substance Abuse					
Osteoporosis					
Diabetes					
Glaucoma					

◆ *For Office Use Only*