

# INTEGRATIVE ACUPUNCTURE

## HEALTH HISTORY QUESTIONNAIRE FOR NUTRITION

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential.* If you have any questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "comments" section. Thanks you.

Name: (First, Last) _____	Date: _____	
Street: _____	City: _____	Zip code: _____
Home Phone: _____	Work Phone: _____	Cell: _____
Email: _____	Date of Birth: _____	Age: _____
Height: _____	Weight: _____	Goal Weight (if applicable): _____
Marital Status: _____	Occupation: _____	
Family Physician: _____	Referred by: _____	

Have you been counseled by a Nutritionist or Dietitian before?    Yes    No
If yes, when? _____
Are you currently under a doctor's care?    Yes    No    If yes, for what?
_____
Have you been diagnosed for a nutrition related problem (such as anemia, high cholesterol, hypoglycemia, gastrointestinal problem, thyroid disorder, etc...)?
Yes    No    If yes, please specify? _____
<b><u>If you believe you have a nutrition related problem or metabolic disorder, you must see a doctor for an accurate diagnosis</u></b>
Main problem/issue you would like help with: _____
How long ago did this problem begin? Please be specific. _____

To what extent does this problem interfere with your daily activities, such as work, sleep and sex? \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what and by whom?  
\_\_\_\_\_

What kinds of treatment/s have you tried to manage your nutrition related problem? Circle all that apply. Herbs Diets (list all) \_\_\_\_\_ Surgery  
Other (explain) \_\_\_\_\_

What is your goal for your nutrition consultation? \_\_\_\_\_

**PAST MEDICAL HISTORY (Circle all that apply)**

Cancer      Diabetes      Hepatitis      High Blood Pressure      Heart Disease  
Rheumatic Fever      Thyroid Disease      Seizures      Stroke      Asthma  
High Cholesterol      Overweight      Underweight      GI problems      Heartburn  
Constipation      Stress      Nausea      History of weight loss/gain  
Venereal Disease      Eating disorders (explain) \_\_\_\_\_

Other (list) \_\_\_\_\_

Allergies (list all – chemical, foods, drugs): \_\_\_\_\_

Surgeries (what/when):  
\_\_\_\_\_

Significant Trauma (auto accidents, falls, etc.../when):  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY (Circle all that apply)**

Cancer      Diabetes      Hepatitis      High Blood Pressure      Heart Disease  
Rheumatic Fever      Thyroid Disease      High Cholesterol      Seizures      Stroke  
Asthma      High Cholesterol      Venereal Disease      Other (list) \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS:** List all medicines taken within the last 2 months (vitamins, drugs, herbs, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Most Recent Lab Results:**

Cholesterol \_\_\_\_\_ HDL \_\_\_\_ LDL \_\_\_\_\_ Triglycerides \_\_\_\_\_ FBS \_\_\_\_\_

Homocysteine \_\_\_\_\_ Blood Pressure \_\_\_\_\_ INR \_\_\_\_\_

Other \_\_\_\_\_

**Are there areas of your life that are stressful? Circle all that apply:**

Home          Work          Family          Psychological Stress          Physical Stress

Do you smoke? No    Yes    If yes how many cigarettes/cigars per day? \_\_\_\_\_

Please describe drug use for non-medical reasons: \_\_\_\_\_

Do you drink alcohol? Yes No    How many per week? \_\_\_\_\_

Do you exercise regularly? Yes No    If yes, what do you do? \_\_\_\_\_

**Nutrition:** How many times per week do you eat/drink the following:

Red meat \_\_\_\_ Poultry products \_\_\_\_ Fish/Shellfish \_\_\_\_ Dairy Products \_\_\_\_

Whole grain foods \_\_\_\_ Fruits/Vegetables \_\_\_\_

Eat out in a restaurant or take food out? \_\_\_\_\_

Have you ever been on a special or restricted diet? (vegetarian, vegan, medical related, other)    Yes    No    If yes, describe \_\_\_\_\_

How many 8 oz glasses of water do you drink per day? \_\_\_\_\_

Please check is you have had any of the following in the last 3 months:

<b>GENERAL</b>			
<input type="checkbox"/> Fevers	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Cravings
<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Bleed/bruise easy
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Peculiar tastes or smells	
<input type="checkbox"/> Sudden energy drop. What time of day? _____			
<input type="checkbox"/> Strong thirst for	<input type="checkbox"/> Hot drinks	<input type="checkbox"/> Cold drinks	

<b>SKIN AND HAIR</b>			
<input type="checkbox"/> Rashes	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching
<input type="checkbox"/> Eczema	<input type="checkbox"/> Pimples	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Loss of Hair
<input type="checkbox"/> Recent moles	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Acne

<b>HEAD, EYES, EARS, NOSE, THROAT</b>			
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Concussions	<input type="checkbox"/> Migraines	<input type="checkbox"/> Glasses
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Night blindness
<input type="checkbox"/> Color blindness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Earaches
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Recurrent sore throats	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Clenching jaw
<input type="checkbox"/> Facial pain	<input type="checkbox"/> Sores on lips and tongue	<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Jaw clicks
<input type="checkbox"/> Headaches, where and when			
<input type="checkbox"/> Any other head or neck problem?			

Name: \_\_\_\_\_ Date: \_\_\_\_\_

<b>CARDIOVASCULAR</b>			
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fainting
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Cold hands/ feet	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Swelling of feet	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Palpitations at rest		<input type="checkbox"/> Varicose or spider veins	
<input type="checkbox"/> Any other heart or blood vessel problems?			

<b>RESPIRATORY</b>			
<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Pain with deep breath	
<input type="checkbox"/> Difficulty breathing lying down		<input type="checkbox"/> Phlegm production. Color? _____	

<b>GENITO-URINARY</b>			
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Impotency
<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Decrease flow
<input type="checkbox"/> Wake at night to urinate. How many times per night? ____			<input type="checkbox"/> Sores on genitals
What color is the urine? Yellow    Pale Yellow    Cloudy    Red tinged Dark Yellow    No color			
<input type="checkbox"/> Any other problems with your genital or urinary systems?			

<b>GASTROINTESTINAL</b>			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Black stool	<input type="checkbox"/> Constipation
<input type="checkbox"/> Gas	<input type="checkbox"/> Belching	<input type="checkbox"/> Rectal pain	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Bloating/edema	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Hernia	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Colitis	<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Abdominal pain/cramps	<input type="checkbox"/> IBS/Crohn's disease
<input type="checkbox"/> Loose stool more than 2x per day	<input type="checkbox"/> Slow digestion	<input type="checkbox"/> Chronic laxative use	<input type="checkbox"/> Acid reflux/GERD
<input type="checkbox"/> Any other problem with stomach or intestine?			

<b>REPRODUCTIVE &amp; GYNECOLOGIC</b>			
Are you pregnant?		Yes	No
Is it possible that you are pregnant?		Yes	No
Number of pregnancies: _____		Live births: _____	Miscarriages: _____

Age at first menses: _____	Premature births: __	Abortions: _____
Duration of menses (number of days flowing): _____	Last PAP: _____	
How many days long is your menstrual cycle: _____		
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Clots
<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Polycystic Ovary Disease	<input type="checkbox"/> Breast lumps
Color of menses blood: Dark Red Bright Red Pale Red Pink Brown Black		
Any unusual characteristics of the blood? (Heavy, scanty): _____		
Do you practice birth control? Yes No If yes, what type? _____ How long? _____		

<b>MUSCULOSKELETAL</b>			
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Rotator cuff	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Foot/ankle pain
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Shoulder pain
<input type="checkbox"/> Hip pain	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Hand/wrist pain
<input type="checkbox"/> Carpel tunnel	<input type="checkbox"/> Sprains/strains	<input type="checkbox"/> Tendonitis	
<input type="checkbox"/> Back pain	<input type="checkbox"/> Low	<input type="checkbox"/> Middle	<input type="checkbox"/> Upper
<input type="checkbox"/> Soreness/weakness of the lower body (back, hip, knee, ankle, foot)			

<b>NEUROLOGICAL &amp; PSYCHOLOGICAL</b>			
<input type="checkbox"/> Seizures	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Concussion
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Numbness/tingling in fingers or toes
<input type="checkbox"/> Bad temper	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Easily susceptible to stress		<input type="checkbox"/> ADD/AHD	<input type="checkbox"/> Manic depression
<input type="checkbox"/> Have you ever treated for emotional problems? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<input type="checkbox"/> Have you ever considered or attempted suicide? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Any other neurological or psychological problems?			

**COMMENTS:** Please tell us briefly of any other problems you would like to discuss.

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