Bellingham Bay Acupuncture PS Jill A Likkel LAc Date ___________________

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention which is not asked on this form, please note it in the *Comments* section. Thank you.

Name ______________________________________ Date of Birth __________________ Age___

Address _______________________________________ Height ______ Weight _____Sex_____
____Employer_____________________________
____Occupation____________________________
Phone # (H) ________________ (W)___________(C)___________Email__________________
Marital Status: _S _M _D _W _P Spouse's Name_______________________
Physician___________________________________ Referred By__________________________
In Emergency Notify __________________________Phone______________________________

Main problem you would like help with:

____

____

____

When did the problem begin (be specific):

____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? ____

____

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

____

What kinds of treatments have you tried?

____

Other concurrent therapies:

____

Past Medical History – please note dates:
Cancer _____________________Diabetes _____________________Hepatitis________________
HIV/AIDS ___________________High Blood Pressure ___________Heart Disease____________
Thyroid Disease ______________Rheumatic Fever ______________Venereal Disease _______
Other____
Surgeries (type & dates)

____

____

Significant Traumas

____

____

Allergies (drugs, chemicals, foods, etc.)

____

____

Occupational Stress (chemical, physical, psychological)
____

Family Medical History__________________ Father Mother Sister Brother (circle)
_ Cancer_ Diabetes_ High Blood Pressure_ Heart Disease_ Stroke_Seizures_Asthma_Allergies
_ Other ____

Medications

What medications / supplements are you taking? ____________________________________
____

____
Have you had many courses of antibiotics recently? _ Lots _ Moderate _ Few _ None

Habits Do you have a regular exercise program? Please describe:
____
Are you or have you been on a restricted diet? What kind & why?
____

____
Please indicate usage per day or per week:
Cigarettes ____per day/Week Alcohol ______ per day/Week Drugs _______ per day/Week
Coffee _______ per day/Week Tea _________ per day/week Soft Drinks ______ per day/week
Sugar ______ per day/week Other ___________________ per day/week
Please describe your average daily diet:
Morning
____
Afternoon
____
Evening
____

Do you suffer from any of the following?

Please check all symptoms that apply:

General

__ Recurrent infections __ Night sweats__ Sweating easily_ Bleed or bruise easily
__Strong thirst (hot or cold) _ Thirst, no desire to drink__ Fatigue__ Sudden energy drops ____
__Poor sleep___ Tremors___ Poor balance__ Edema__ Underweight __ Overweight

Skin

__Rashes____Itching___ Eczema___ Oozing___ Pimples___ Dry skin/scalp___ Recent moles
_ Change in hair/skin___________________ Other skin problems________________________

Head/Eyes/Ears/Nose/Throat

_ Headaches Where ________________When ________________ __ Migraines
_ Dizziness _ Earache _ Discharge from ear _ Poor hearing _ Ringing in ears
_ Blurry vision _ Night blindness _ Color blindness _ Spots in front of eyes _ Eye pain --
_Excessive tearing _ Squint _ Glasses _ Sore eyes
_ Facial pain _ Nose bleeds _ Nasal discharge _ Blocked nose _ Snoring
_ Grinding teeth _ Teeth problems _ Recurrent sore throat _ Hoarseness _ Tonsillitis
_ Swollen glands _ Sores on lips/mouth _ Other _______________

Cardiovascular

_ Pacemaker _ High blood pressure _ Low blood pressure _ Chest discomfort/pain

_ Heart palpitations _ Cold hands or feet _ Swelling of hands or feet _ Blood clots
_ Spider veins _ fainting _ other ____

Respiratory
_ Difficulty breathing _ Pain with breathing _ Shallow breathing _ Shortness of breath
_ Production of Phlegm, color ________________ _ recurrent cough _ Coughing blood
_ Bronchitis _ Pneumonia _ Asthma/Wheezing _ Other ________________________________

Digestion
_ Bad breath _Change in appetite _ Nausea _ Vomiting _ Heartburn _ Indigestion _Belching
_ Abdominal pain or cramps _ Weight gain _ Weight loss _ Loose stools/diarrhea
_ Strong smelling stools _ Bloody stools _ Pale stools _ Green stools _ Black stools
_ Constipation (not daily or with difficulty) _ Pain with passing stools _ Gas _ Rectal pain
_ Hemorrhoids _ Anorexia nervosa _ Bulimia _ Other ___________________________________

Genito-urinary
_ Pain on urination _ Urgency with urination _ Frequent urination _ Blood in urine
_ Decrease in urinary flow _ Unable to hold urine _ Incontinence at night _ Dribbling urination
_ Kidney stones _ Prostate problems _ Impotency _ Change in sexual drive
_ Do you wake to urinate? How many times? __________ Other __________________________

Gynecological
# of pregnancies ____________ # births ____________________# premature births ____________
Age of 1st menses ___________ # days between menses _____ Duration of menses _________
1st day of last menses _______ Age of menopause __________ Date of last PAP ____________
_ PMS _ Irregular periods _ Painful periods _ Light periods _ Heavy periods _ Clots, size?__
_ Fibroids _ Endometriosis _ Infertility _ vaginal discharge _ Vaginal sores
_ Breast lumps _Breast tenderness _ Nipple discharge _ Other ________________
Do you practice birth control? _ yes _ no what type & how long?_________________________
Are you now pregnant? _ yes _ no

Musculoskeletal
_ Neck ache/pain _ Back ache/pain _ Knee ache/pain _ Shoulder pain _ Hand/wrist pain
_ Foot/ankle pain _ Joint/Bone problems _ Torn tissues _ Prostheses _ Muscle pain
_ Muscle weakness _ Hernia _ Other ____

Neurological
_ Seizures _ Nerve damage _ Paralysis _ Stroke __Tremor _ Sleep disorder _ Concussion
_ Vertigo _ Lack of coordination _ Loss of balance _ Poor memory _ Difficulty in concentrating

Behavioral
_ Vacant _ Moody _ Easily susceptible to stress _ Aggressive/Bad temper _ Lose control of emotions _ Anxiety _ Panic attacks _ Depression _ Fear _ Substance abuse _ Other _____
Have you ever been treated for emotional problems? _ yes _ no
Have you ever considered or attempted suicide? _ yes _ no

Please note the degree of severity of your problem now:
No Problem ____Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:
No Problem____ Worst Imaginable