CODY ZHANG
R. Ac & R. TCM.P
ACUPUNCTURE AND HERBAL MEDICINE

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*			☐ M ☐ F		**DOB:**	
Telephone #:					**Email:**	
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Previous or referring doctor:					**Date of last physical exam:**	
Contact # for doctor:					**Today's Date:**	
What is your main concern today?	_____					
How did you hear about our clinic?	_____					

PERSONAL HEALTH HISTORY

Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength/Dosage	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Pain	Do you have pain?		☐ Yes	☐ No
	If yes, please rate that pain on a scale of 1-10 (10 being the worst):		1-2-3-4-5-6-7-8-9-10	
	Is the pain better at rest, with activity or neither?		☐ Rest ☐ Activity ☐ Neither	
	Does cold or heat make the symptoms better?		☐ Better w/ heat ☐ Better w/ cold	
Sleep	Do you feel rested after sleep?		☐ Yes	☐ No
	About how many hours do you sleep per night?		_____	
	On a scale of 1-10 (1 being the lowest), where is your energy at in general?		1-2-3-4-5-6-7-8-9-10	

Ear, Nose & Throat	Do you ever have any ringing in your ears?		☐ Yes	☐ No
	Do you ever experience any dizziness?		☐ Yes	☐ No
	Do you ever have any headaches?		☐ Yes	☐ No
	Do you ever have a residual taste in your mouth?		☐ Yes	☐ No
	If yes, what taste do you experience?		_____	
Stool/Urine	How many times a day do you have a bowel movement?		_____	
	How often per day do you urinate?		_____	
	How is the volume of your urination?		☐ Large ☐ Average ☐ Low	
	How is the volume of your bowel movements?		☐ Large ☐ Average ☐ Low	
	What is the quality of your bowel movements?		☐ Hard ☐ Soft ☐ Loose	
Chills/Fever	Do you ever have chills, fever or both?		☐ Chills ☐ Both ☐ Fever ☐ Alternating	
	If yes, are you more comfortable in hot or cold environments?		☐ Hot ☐ Cold	
Sweating	Do you sweat easily?		☐ Yes	☐ No
	What time of the day do you sweat the most?		☐ Day	☐ Night
	What is the quality of your sweat?		☐ Oily ☐Watery	☐ Cold
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
	# of meals you eat in an average day?	_____		
	How much water do you drink roughly per day (in cups)?	_____		
	Do you feel thirsty often?	☐ Yes	☐ No	
	What kind of drinks do you prefer?	☐ Hot ☐ Cold ☐ Room temp.		
	Rank salt intake	☐ Hi	☐ Med	☐ Low
	Rank fat intake	☐ Hi	☐ Med	☐ Low
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	How many drinks per week?			
	Are you concerned about the amount you drink?		☐ Yes	☐ No
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?		☐ Yes	☐ No
Sexual Health	Do you have any discomfort with intercourse?		☐ Yes	☐ No
	Any HIV or STD history?		☐ Yes	☐ No
Personal Safety	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from your penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

Consent Form

Financial Policy

Payment is due at the time of treatment. The sustainability of our clinic depends on our patients keeping their appointment times or making them available to others who need them in a timely fashion. We ask for 24 hours notice for any rescheduling or cancellations so that we may fill the appointment time. All appointments that are rescheduled or cancelled with less than 24 hours notice and appointments missed without notice will be charged the regular fee for that appointment.

I, _____(name printed) agree to the above policy.
X
Signature_____ Date_____
X X

Patient Advisory to Consult a Physician

The law of British Columbia requires that we advise you to consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal treatment. These modalities have a lot to offer as a health care system, but they are not a substitute for the resources available through a biomedical physician.

THE UNDERSIGNED AFFIRMS THAT _____(patient) HAS BEEN ADVISED
X
BY _____(licensed acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

Privacy Policy

As we do not transmit health information electronically, we are not technically covered under HIPPA. However, your privacy is important to us and we do not share your information under any circumstances without your consent. I, _____consent to receive acupuncture treatment at Electra Health Floor in a group setting,
X
and that it is possible that other people will overhear conversations between my acupuncturist and myself. I understand that I can choose not to mention, or have my acupuncturist not mention, any sensitive health information in the communal clinic space. This information can be addressed in writing or in private. I understand the privacy policies of this office in regards to my written health record that remain in effect regardless of the setting in which I am treated.
I agree to the above policy.

Signature: _____

Date: _____