Malvin Finkelstein, L.Ac. - Eugene Center for Acupuncture - 2767 Friendly Street, Eugene, OR 97405 - 541-683-9230

Health History Questionnaire (Page 1)

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you.

Name _____Date _____Phone: home_____

work _____cell _____; Email_____

Street _____ City_____State _____Zip_____

Age _____Date of birth _____Sex ____Marital Status _____Ht. _____Wt._____

Occupation_____ Employer's name _____Address_____

In emergency, contact_____ Relationship_____Phone_____

Insurance co: name_____ Policy #_____ Group # _____

Name of person carrying insurance_____ Relationship_____

Medical history:

Referred by_____

Have you been treated by acupuncture before? ☐ yes ☐no When?_____Where?_____

By whom?_____ For what condition? _____Did it help? ☐ yes ☐no

Significant illnesses: ☐ cancer-location _____ ☐ Diabetes ☐Seizures ☐ Hepatitis-type ____

☐ High blood pressure ☐Heart disease ☐ HIV+ ☐AIDS ☐ Thyroid disease ☐ Auto-immune _____

Surgeries -what type, when_____

Allergies (drugs, chemicals, food) _____

Stress: Occupational Family Health; Do you: exercise stretch yoga tai qi/qigong meditate pray

Medicines taken within the last two months (drugs, vitamins, herbs):_____

_____ Please describe your average daily diet: Morning_____

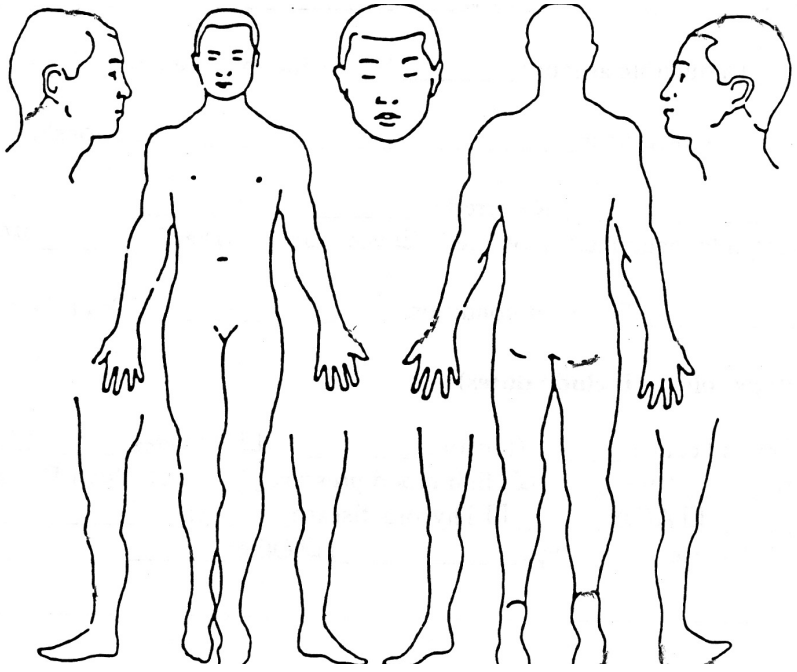
Afternoon_____Evening_____

Each day: How many packs of cigarettes?___How much coffee?_____ tea?_____soda? ____ alcohol? _____

Family Medical History (Please specify family member):

Diabetes Cancer High Blood Pressure Seizures Asthma Allergies Heart Disease Stroke

Current condition: Indicate painful or distressed areas:



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Health History Questionnaire (Page 2)

Name_____Date_____

Condition(s) to be treated _____Diagnosis _____
Is this condition ☐ new? ☐ an aggravation of an old condition?
Is your condition ☐ worsening ☐ improving? ☐ constant? ☐ comes and goes?

Describe **history of condition**. Please include:
When it **started**, what **caused** it, how it has **progressed**, when it has **flared up**, how **frequently** it bothers you:

_____

_____

_____

_____

_____

_____

_____

What makes it worse? _____What makes it better? _____

What type of treatments/drugs have you tried? _____

Which treatments/drugs helped? _____

List health professionals who have treated this condition _____

Circle the number below that describes how your condition interferes with:

Work
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

General Activity
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Sleep
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Walking
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Other _____
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

If you have pain, where is your pain? _____
Does it have a: ☐ fixed location? ☐ change locations?
Does it radiate? ☐ yes ☐ no From where to where?_____
Is your pain: ☐ dull ☐ sharp/stabbing ☐ burning ☐ throbbing ☐ aching
Do you have: ☐ pins and needles ☐ numbness
Is pain worse: ☐ standing ☐ walking ☐ sitting ☐ lying down

What movements are restricted or painful? _____

Please rate your pain level **NOW:**
0 1 2 3 4 5 6 7 8 9 10

Please rate your **typical or AVERAGE** pain level:
0 1 2 3 4 5 6 7 8 9 10

Please rate your pain level **at its WORST:**
0 1 2 3 4 5 6 7 8 9 10

Please rate your pain level **at its BEST**:
0 1 2 3 4 5 6 7 8 9 10

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Health History Questionnaire (Page 3)

Name_____Date_____

Please check if you have had (in the last three months):

GENERAL:

☐ Poor appetite ☐ Poor sleeping ☐ Fatigue ☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily
☐ Poor balance ☐ Bleed or bruise easily ☐ Sudden energy drop – what time of day?_____

SKIN AND HAIR:

☐ Rash ☐ Eczema ☐ Dermatitis ☐ Psoriasis ☐ Hives ☐ Recent moles ☐ Loss of hair
☐ Ulcerations ☐ Other_____

HEAD, EYES, EARS, NOSE, AND THROAT:

☐ Headaches ☐ Migraines ☐ Sinus problems ☐ Concussions ☐ Nose bleeds ☐ Eye pain
☐ Poor vision ☐ Glasses ☐ Night blindness ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration
☐ Poor hearing ☐ Ear aches ☐ Ringing-ears ☐ Facial pain ☐ TMJ ☐ Recurrent sore throat
☐ Other _____

CARDIOVASCULAR:

☐ High blood pressure ☐ Chest pain ☐ Irregular heartbeat ☐ Dizziness ☐ Fainting ☐ Stroke
☐ Blood clots ☐ Other _____

RESPIRATORY:

☐ Cough ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Pain with deep breath ☐ Coughing blood
☐ Difficulty breathing when lying down ☐ Production of phlegm – color _____ ☐ Other _____

GASTROINTESTINAL:

☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Gas ☐ Belching ☐ Blood in stool
☐ Bad breath ☐ Rectal pain ☐ Hemorrhoids ☐ Abdominal pain or cramps ☐ Chronic laxative use
☐ Other _____

GENITO-URINARY:

Urinary: ☐ Pain ☐ Frequency ☐ Urgency ☐ Decrease in flow ☐ Blood in urine ☐ Unable to hold urine
☐ Bladder infection ☐ Kidney infection ☐ Kidney stones ☐ Impotency ☐ Genital sores
☐ Other _____

PREGNANCY & GYNECOLOGY:

Number of: Pregnancies _____Births _____Miscarriages_____ Abortions _____

Age at first menses _____Age at menopause _____Period between menses_____Duration_____
Periods: ☐ Heavy ☐ Light ☐ Short ☐ Long ☐ Irregular ☐ Cramps and pain-when, where_____

☐ PMS – Describe _____ ☐ Vaginal discharge ☐ Vaginal sores

☐ Breast lumps; Do you practice birth control? ☐ yes ☐ no What type and for how long?_____

☐ Menopausal symptoms – Describe _____

MUSCULOSKELETAL PAIN:

☐ Neck ☐ Low Back ☐ Mid-Back ☐ Upper Back ☐ Shoulder ☐ Arm ☐ Hands, fingers
☐ Hips ☐ Legs ☐ Knees ☐ Feet, toes ☐ Other _____

NEUROLOGICAL:

☐ Seizures ☐ Areas of numbness, weakness ☐ Concussion ☐ Loss of balance ☐ Other _____

PSYCHOLOGICAL:

☐ Anxiety ☐ Depression ☐ Bad temper ☐ Eating disorder ☐ Bipolar ☐ Other _____
Have you every considered or attempted suicide? ☐ yes ☐ no

COMMENTS:

Please tell us of any other problems you would like to discuss:

PAIN RATING SCALE

RATING	DESCRIPTION	DEFINITION
0	No Pain	Pain free!
2	Minimal	Pain is barely noticeable; tightness
3	Mild	Feel a low level of pain entering awareness only when my attention is devoted to it
4	Uncomfortable	Pain is troubling but can be ignored most of the time; am able to continue activities
5	Moderate	Moderate pain but no break in activity or concentration; guarded movement patterns
6	Distracting	Pain is troubling and breaks through concentration but is tolerable; activity level changes
7	Distressing	Pain is intense and preoccupies my thinking; can complete tasks but it is difficult and must cease some demanding activities; considering pain medication or other pain reducing agent
8	Intense	Severe pain that makes concentration difficult; can do only non-demanding activities; taking pain medication, etc. Can't carry on a conversation well, pacing, etc.
9	Severe	Can't concentrate on anything else; sweating, unsteady breathing, can do almost nothing. Can barely talk
10	Immobilizing	Excrutiating pain, constant; unable to move