PATIENT HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____

Birth Date: _____ **Height:** _____ **Weight:** _____

Is your condition due to _____an accident _____an illness ____other _____
Did your accident occur while at work _____ Yes _____ No When _____
Were you involved in an automobile accident? _____Yes ____ No When _____

State your major complaint, injury or illness: _____

_____

When was the first time you were aware of this condition? _____

How did this condition develop? _____

Have you received any treatment for this condition? _____ Yes _____ No

Where? _____

When? _____

By Whom? _____

What was the diagnosis? _____

What were the results of the treatment? _____

Have you ever been advised to have any surgery which was not done? _____

_____

Has the condition been getting: _____ better _____worse _____ staying the same

Are you experiencing physical, mental, or emotional stress at _____ home or _____ at work or ____other

How has this condition affected the following:

Your home life: _____

Your work experience: _____

Your social life: _____

Your ability to exercise: _____

Rest and Sleep: _____

Other: _____

State your injuries you have had, related or otherwise, to your condition: _____

_____

Please list other comments or symptoms
You feel would be beneficial to
Your treatment or condition:

_____

_____

_____

_____

_____

_____

_____

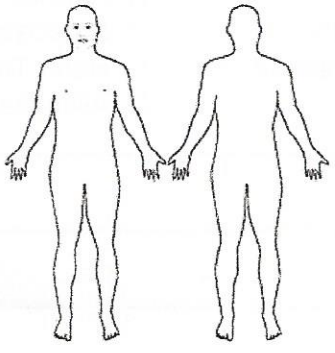
If you are in pain, mark the location of your pain on the figure below. Describe the type, frequency, intensity and duration of your pain, as well as any activity which brings on or aggravates the pain. (ie abnormal sharp pain, every 30 seconds, for the last two hours when standing or sitting.

_____

_____

_____

_____



Name: _____ **Date:** _____

Past Medical History

Birth: anything significant about your birth? _____

_____

Vaccination History: Any reaction that you remember? _____

_____

Childhood Illnesses: Any surgery or accidents? List in Chronological order and indicate length of illness or injury.

Age 0-6:

Age 7-12:

Age 13-20:

Age 21-30:

Age 31-40:

Injuries: (auto accidents, falls, etc.) _____

☐ **Broken Bones** ☐ **Dislocations** ☐ **Sprains**
☐ **Concussion or Head Injury** ☐ **Loss of Consciousness**

Personal History: Have you ever had/do you currently have:

☐ Scarlet Fever	☐ Gallbladder Disease	☐ Gonorrhea/Syphilis	☐ Heart Disease
☐ Rectal Disease	☐ Nephritis	☐ Epilepsy	☐ Pneumonia
☐ Polio/Meningitis	☐ Hay Fever/Asthma	☐ Nervous Breakdown	☐ Anemia
☐ TB/Angina	☐ Miscarriage	☐ Boils/infections	☐ Diabetes
☐ High Blood Pressure	☐ Pleurisy	☐ Mental disorder	☐ Hepatitis
☐ Jaundice	☐ Cancer	☐ Bladder Disease	☐ Drug Problem
☐ Food/Drug Poisoning	☐ Alcoholism	☐ Rheumatic Fever	☐ A.I.D.S.

Family History: Has you, father or mother had:

☐ Cancer	☐ Epilepsy	☐ Arthritis	☐ Stroke
☐ Diabetes	☐ Alcoholism	☐ Scoliosis	☐ Mental Disorder
☐ High Blood Pressure	☐ Kidney Disease	☐ Heart Trouble	☐ Drug Problem
☐ Glaucoma	☐ Asthma	☐ Allergies	☐ TB
☐ Ulcers	☐ Other: _____		

Additional Family History: _____

_____

Name: _____ Date: _____

PATIENT PROFILE

It is very important to know how long a patient has experienced his/her symptoms. Thus, it is essential to indicate time on the symptoms.

Indicate with one check any condition that you sometimes experience; use two checks for those which often occur, and three checks for symptoms that are a major concern.

WATER ELEMENT

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Lower backache/neck pain
- ☐ Sinus congestion
- ☐ Edema
- ☐ Darkness under the eyes
- ☐ Emotional instability
- ☐ Aversion to cold
- ☐ Hair Thinning or loss
- ☐ Premature aging
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Perspire very easily
- ☐ Weakness of legs/knees
- ☐ Asthmatic cough
- ☐ Rapid weight change
- ☐ Loose teeth
- ☐ Reduced sexual energy
- ☐ Thyroid problems
- ☐ Diabetes

METAL ELEMENT

- ☐ Bronchitis
- ☐ Asthma
- ☐ Shallow breathing
- ☐ Cough
- ☐ Sinus congestion
- ☐ Nasal infections

PAIN

(please describe below)

_____

_____

_____

WOOD ELEMENTS

- ☐ Headaches
- ☐ Migraines
- ☐ Ringing in the ears
- ☐ Poor eyesight
- ☐ Eye infections
- ☐ Dry eyes
- ☐ Eczema
- ☐ Shingles
- ☐ Herpes simplex
- ☐ Warts
- ☐ Nervousness
- ☐ Convulsion, spasms
- ☐ Irritability
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Vomiting
- ☐ Gallstones
- ☐ Indecisive
- ☐ Fullness below ribs
- ☐ Shoulder/neck tension
- ☐ Insomnia 11 PM - 3 AM

OTHER

- ☐ Fatigue
- ☐ Arthralgia
- ☐ Sciatica/nerve pain
- ☐ Cold hands/feet
- ☐ Tendonitis
- ☐ Bursitis

OTHER COMMENTS

_____

_____

_____

FIRE ELEMENT

- ☐ Dry scalp
- ☐ Skin eruptions, rashes
- ☐ Cysts, tumors
- ☐ Ear Infections
- ☐ Sore throat, tonsillitis
- ☐ Lymphatic swelling
- ☐ Hot palms and soles
- ☐ Heart palpitations
- ☐ Aversion to heat
- ☐ Bitter taste in mouth
- ☐ Gum problems
- ☐ Nose bleed
- ☐ Facial redness
- ☐ Itching/burning skin
- ☐ Hot hands/feet
- ☐ Thirst
- ☐ Vivid dreaming
- ☐ Dark urine
- ☐ Night sweats

EARTH ELEMENT

- ☐ Indigestion
- ☐ Flatulence
- ☐ Food allergy
- ☐ Stomach ache/ulcer
- ☐ Diarrhea
- ☐ Anemia
- ☐ Halitosis
- ☐ Sores in mouth
- ☐ Heartburn
- ☐ Strong appetites
- ☐ Weak appetite
- ☐ Nausea
- ☐ Abdominal bloating
- ☐ Low body weight