Earley Wellness Group

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Your Health History

Please take a moment to complete the attached questionnaire. Your effort is greatly appreciated and will make an important contribution to your overall health care.

Name: _____

Address: _____
Street Apt # City State Zip Code

Phone (h) _____ (c) _____ (w) _____

Date of Birth_____Age _____Email_____

Occupation_____Employer_____

Relationship Status (optional)

Single _____ Married _____ Partnered _____ Divorced _____ Separated _____ Widowed_____

Persons in household and how they relate to you: _____

How did you find out about us? _____

Does anything limit you from care? (yes __) (No) Explain_____

_____

What concerns would you like to address in your acupuncture treatments? How long have you had the condition(s)? What Kind(s) of treatment have you tried?

What type(s) of health related issues, hospitalizations, and surgeries have you had in the past?

Year/Condition_____

Year/Condition_____

Year/Condition_____

Medications: List all current over-the-counter & prescription medications, herbs, and vitamins

Name	Dose/amount	How often?

List the types of foods you eat: _____

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Snacks & times eaten: _____

What foods do you crave? _____

Do you exercise regularly? Yes ____ No ____

Type of Exercise	How often?	How long?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Habits:
Do you smoke? Y N How much a day? _____ Since_____

Do you take recreational drugs? Y N What Kind? _____

How many hours do you sleep in general? _____ Do you feel rested when you wake? _____

Diet: How much caffeine do you drink a day (include: coffee, tea, colas, & energy drinks)? _____

What kind of alcohol do you usually drink? _____ Avg. # of drinks per week: _____

How much water do you drink per day? _____

Please rate on a scale of 1-10 (1=worst & 10=best):

Your relationship with your health _____ Your relationship with your work _____

Your relationship with yourself _____ Your relationship with other _____

Your interest in lifestyle advice _____

<u>Please check any of the following that apply to you:</u>

Contributing factors to lack of personal optimum health:

____Lack of motivation ____Lack of information

____Lack of time ____Contradictory information

____Inability to follow through ____Circumstances

Areas that you feel could be improved in your life:

____Diet ____Physical activity ____Time management ____Priorities ____Outlook

Other: _____

Please check if you have or have had any of the following conditions within the past 3 months:

___Poor appetite ___Poor sleeping ___Fatigue ___Fevers ___Chills

___Night Sweats ___Sweat easily ___Tremors ___Cravings ___Change in appetite

___Poor balance ___Bleed or bruise easily ___Localized weakness ___Weight loss ___Weight gain

___Peculiar taste ___Desire hot food ___Desire cold food ___Strong thirst (hot/cold) ___Sudden energy drop

___time of day Favorite season_____ Lease favorite season_____

Skin & Hair:

___Rashes ___Ulcerations ___Hives ___Itching ___Eczema

___Pimples ___Dandruff ___Dry skin ___Loss of hair ___Change in hair or skin texture

Other: _____

Musculoskeletal:

___Joint disorders ___Weakness in muscles ___Pain/Soreness in muscles

___Difficult walking ___Tremors ___Cold hand/feet ___Swelling of hands/feet

___Back pain ___Spinal curvature ___Hernia ___Numbness ___Tingling

___Neck tightness ___Neck pain ___Shoulder pain ___Hand /wrist pain ___Hip pain

___Knee pain ___Sprain of joint Other: _____

Head, Eyes, Ears, & Throat:

___Dizziness ___Concussions ___Migraines ___Glasses/lens ___Eye strain

___Eye pain ___Color blindness ___Night blindness ___Poor vision ___Cataracts

___Blurry eye vision ___Earaches ___Ringing in the ears ___Poor hearing ___Sore throat

___Spots in front of eyes ___Sinus problems ___Nose bleeding ___Grinding teeth ___Teeth problems

___Facial pain ___Jaw clicks ___Sores on lips/tongues ___ Difficulty swallowing

Other: _____

Cardiovascular

___High blood pressure ___Low blood pressure ___Chest pain ___Palpitation ___Fainting

___Irregular heart beat ___Rapid heart beat ___Varicose veins Other: _____

Respiratory

___Cough ___Coughing blood ___Wheezing ___Difficulty in breathing ___Bronchitis

___Pneumonia ___Chest pain ___Production of phlegm-what color? _____

Other: _____

Gastrointestinal

Bowel movements: Frequency_____ ___Loose Stool ___Well Formed ___Constipation

___Fluxuate between loose and constipated Other: _____

___Nausea ___Vomiting ___Diarrhea ___Constipation ___Gas

___Belching ___Black stools ___Blood in stools ___Indigestion ___Bad breath

___Rectal pain ___Hemorrhoid ___Abdominal cramp/pain ___Gallbladder problem

___Parasites ___Chronic laxative use

Neuro-psychological

___Loss of balance ___Lack of coordination ___Concussion ___Depression ___Anxiety

___Stress ___Bad temper ___Bi-polar Other: _____

Genitourinary

___Pain on urination ___Frequent urination ___Blood in urine ___Urgency to urinate ___Kidney stones

___Unable to hold urine ___Dribbling ___Pause in flow ___Frequent urinary tract infections

___Pain in genitals ___Itching of genitals Other: _____

Female

___Frequent vaginal infections ___Pelvic infection ___Endometriosis ___Vaginal discharge ___Fibroids

___Ovarian cysts ___Irregular periods ___Clots ___Pain/cramps prior/during period

___Breast tenderness ___Breast lumps ___Fertility problems ___Moodiness relate to periods

___Low libido ___Hot flashes ___Vaginal dryness Other: _____

# of pregnancies_____ #of births_____ Miscarriages_____ Abortions_____ Premature births_____

___Sexually active ___Use contraception ___Sexually transmitted infection ___Sexually satisfied ___Sexual trauma

Male

___Prostate problems ___Discharge ___Impotence ___Frequent seminal emission

___Fertility problems ___Ejaculation problems ___Painful/swollen testicles ___Low Libido ___Hot Flashes

___Sexually active ___Use contraception ___Sexually transmitted Infection ___Sexually satisfied ___Sexual trauma

Other: _____