

## HEALTH HISTORY QUESTIONNAIRE

**PATIENT'S NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(Physical Exam) BP: (L or R Arm) \_\_\_\_\_ SYS \_\_\_\_\_ DIA \_\_\_\_\_ Pulse (before treatment) Weight: \_\_\_\_\_

BP: (L or R Arm) \_\_\_\_\_ SYS \_\_\_\_\_ DIA \_\_\_\_\_ Pulse (after treatment) Temp: \_\_\_\_\_ (F)

**MAJOR COMPLAINT(S):**

1. COMPLAINT		2. COMPLAINT		3. ANY OTHER COMPLAINT(S)
				e.g., sinuses, asthma, hormone issues, diabetes, digestive troubles, fatigue, sleep problems, etc.
Onset:	How long?	Onset:	How long?	A
Previous Hx:	How happen?	Previous Hx:	How happen?	
S/SX:		S/SX:		B
Pain 1-10; 10 = worst:		Pain 1-10; 10 = worst:		
Type of pain:		Type of pain:		C
Constant/Intermittent:		Constant/Intermittent:		
Duration? daily, weekly...)		Duration? daily, weekly...)		D
Aggravates?		Aggravates?		
Makes better?		Makes better?		E
Does NOT work?		Does NOT work?		
Wes. Med DX?		Wes. Med DX?		Misc. Notes:
Misc. Notes:		Misc. Notes:		

**REVIEW OF SYSTEMS**

**FAMILY HISTORY**

PE	WNL	AB-NML	REASON	Who	What Problems?	Are they receiving care?	
						Yes	No
Constitution							
Head / Mental							
HA's							
Eyes							
Ears							
Nose							
Throat							
Chest							
Heart							
Respiratory							
Stomach							
Abdomen							
Skin							

**L.Ac's Signature:** \_\_\_\_\_ **TX:** \_\_\_\_\_ (\_\_\_\_\_ of \_\_\_\_\_) **or TX/HC:** (\_\_\_\_\_ of \_\_\_\_\_)

**HEALTH HISTORY QUESTIONNAIRE**

**SLEEP PATTERNS:**

Has your sleep been disrupted in any of the following ways?

- 1. Do you have trouble falling asleep? yes \_\_\_\_\_ no \_\_\_\_\_
- 2. Is your sleep restful (do you wake refreshed)? yes \_\_\_\_\_ no \_\_\_\_\_
- 3. Do you awaken in the middle of the night as a result of your problem(s)? yes \_\_\_\_\_ no \_\_\_\_\_
- 4. Do you wake earlier than you normally would? yes \_\_\_\_\_ no \_\_\_\_\_

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- 1. Are you discouraged with your current health status? yes \_\_\_\_\_ no \_\_\_\_\_
  - 2. If you are NOT discouraged, what adjective best describes how you view your health? \_\_\_\_\_
  - 3. How do your health problem(s) affect your relationship(s)? \_\_\_\_\_  
Work? \_\_\_\_\_  
Family/Friends? \_\_\_\_\_
  - 4. What hobbies or activities would you resume if it weren't for your health issues? \_\_\_\_\_  
\_\_\_\_\_
  - 5. Would you agree that your health seems to be having a negative affect on your life? yes \_\_\_\_\_ no \_\_\_\_\_
  - 6. How much younger would you feel if your health concerns could be erased away? \_\_\_\_\_
  - 7. If your health problems aren't resolved, and they have been going on for \_\_\_ months/years, what will be the result if they continue on for another \_\_\_ months/years? \_\_\_\_\_
  - 8. On a scale of 1 -10, with ten being the highest, how committed are you of wanting to rid yourself of these problems and feeling great? \_\_\_\_\_
  - 9. Assuming that we could help you with your condition, is there anything that would prevent you from following through with the treatment plan? yes \_\_\_\_\_ no \_\_\_\_\_
  - 10. Are there any other barriers to your commitment, e.g., time, transportation, other?  
Please specify: \_\_\_\_\_

**TX: \_\_\_\_\_ (\_\_\_\_\_ of \_\_\_\_\_)**

**L.Ac's Signature: \_\_\_\_\_**

**TX/HC: \_\_\_\_\_ (\_\_\_\_\_ of \_\_\_\_\_)**

PATIENT NAME: \_\_\_\_\_

Total # of Health Boxes: \_\_\_\_\_

Total # of Tongue Tests: \_\_\_\_\_

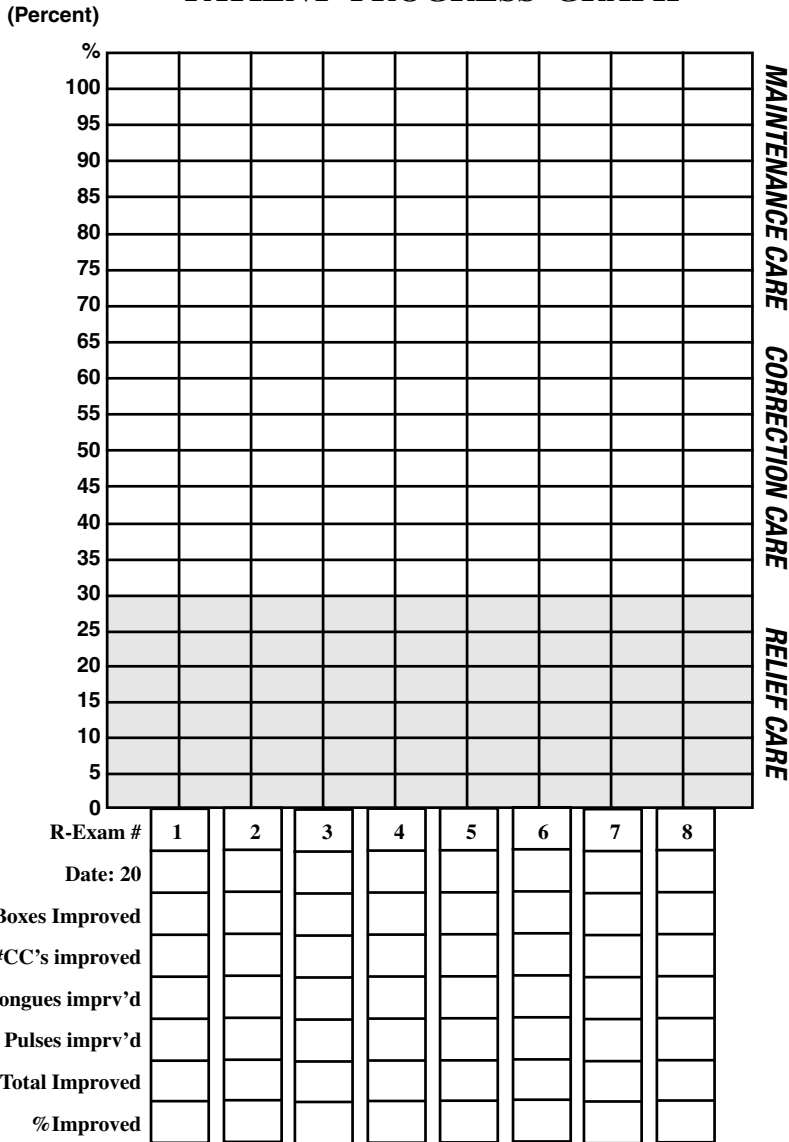
Total # of Pulse Tests: \_\_\_\_\_

Total # of Chief Complaints: \_\_\_\_\_

Grand Total: \_\_\_\_\_ (100%)

Point Value of each: \_\_\_\_\_

**PATIENT PROGRESS GRAPH**



**Major Complaint(s):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**Tongue Qualities:**

Color	
Shape	
Size	
Coat	

**Positive Pulse Tests:**

R-Exam #	1	2	3	4	5	6	7	8
Ht								
SI								
Liv								
GB								
Kid								
UB								

R-Exam #	1	2	3	4	5	6	7	8
Lu								
LI								
Sp								
St								
Kid								
UB								

**Baseline Pulse:**

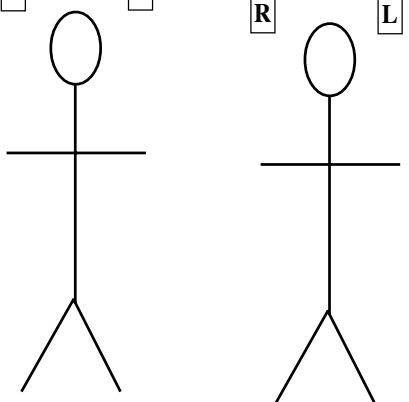
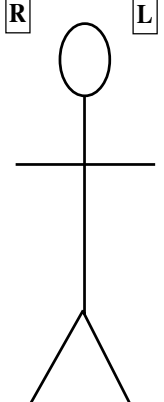
	S		
L	M		
	D		
		<i>Cun</i>	<i>Guan</i> <i>Chi</i>
	S		
R	M		
	D		

**L.Ac's Signature:** \_\_\_\_\_

# ACUPUNCTURE TREATMENT PLAN

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

EXISTING CONDITION(s) for which the Patient is currently being treated:

S	COMPLAINT	STATUS % Better/Worse	PAIN 1-10; 10=worst	VESSELS (involved)	ACUPOINTS  R L	RE-INSERT (acupoints)  R L
1.				_____		
2.			_____			
3.			_____			
4.			_____			
5.			_____			
O				P	Circle which: Herbs Acup. Acup/Stim. TDP	
A					TX PLAN: _____ 1x/week; _____ 2x/week; _____ 3x/week; _____ other	

L.Ac's Signature: \_\_\_\_\_ TX TIME TOTAL: \_\_\_\_\_ (minutes)

## HERBAL CONSULTATION

BP (L or R arm): \_\_\_\_\_ SYS; \_\_\_\_\_ DIA; \_\_\_\_\_ Pulse (before TX)  
 BP (L or R arm): \_\_\_\_\_ SYS; \_\_\_\_\_ DIA; \_\_\_\_\_ Pulse (before TX)

CHIEF COMPLAINT(s) \_\_\_\_\_

TCM DX: \_\_\_\_\_

Temp./Palpation DX: \_\_\_\_\_ Ear DX: \_\_\_\_\_

	R		L	
	Cun	Guan	Chi	PULSE DX:
S:	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
M:	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
D:	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____

## HERBAL FORMULA

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_

Instructions: \_\_\_\_\_ spoons; \_\_\_\_\_ x's/day

Green  
Yellow  
Red  
Blue

TX: \_\_\_\_\_ (\_\_\_\_\_ of \_\_\_\_\_)  
 (or) TX/HC: (\_\_\_\_\_ of \_\_\_\_\_)

Total Grams: \_\_\_\_\_

L.Ac's Signature: \_\_\_\_\_