Terry Rudd, ND, L.AC.
Acupuncture and Chinese Medicine
Health History Questionnaire

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

Date: _____

Name: _____ Birthplace: _____

Date of Birth: _____

Address: _____

Age: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Primary Care Provider: _____ Referred by: _____

Occupation: _____ Height: _____ Weight: _____

Relationship Status: ○ Single ○ Married or Partnered ○ Divorced ○ Widowed

Have you ever been treated with acupuncture or Chinese medicine before?	○ Yes	○ No
Do you take an anti-coagulant medication (i.e. a blood-thinning drug) or Lithium?	○ Yes	○ No
Do you take any drugs or supplements or have any medical condition that may contraindicate Chinese herbal therapies?	○ Yes	○ No
Do you have an electronic implant like a pacemaker, or do you have any other condition that may contraindicate electro-stimulation treatment?	○ Yes	○ No

What is your main complaint for this visit?

When did this problem begin?

Does it interfere with daily activities? ○ Yes ○ No

What improves and what aggravates your main complaint?

Describe any previous diagnosis or treatments you have received for this complaint.

Please list all current and occasional drugs and supplements.

Current drugs and supplements:

Occasional drugs and supplements:

Please list all drug allergies:

Please list all other allergies (foods, animal dander, etc.):

Please list all significant surgeries and dental work:

Please list all major injuries and accidents (including birth trauma):

Please describe any current or historical mental or emotional disorders or predominant emotions:

How physically active are you each day? Include exercise and all other activity.

○ Inactive ○ Slightly Active ○ Moderately active ○ Very Active ○ Extremely Active

Diet

How many times a day do you eat? _____

Please describe your typical menues for each meal

Morning

Afternoon

Evening

Between Meals

Please indicate your weekly use, if any, of the following:

Sodas or other canned beverages _____

Coffee _____

Cigarettes _____

Recreational Drugs _____

Please check any historically significant or recent symptoms.

General

- ☐ Aversion to cold (not improved with warmth
- ☐ Fear of Cold (improved with warmth)
- ☐ Chilliness of specific areas of the body
- ☐ Fever
- ☐ Morning hot flashes
- ☐ Afternoon hot flashes
- ☐ Hot hands and feet
- ☐ Fever and chills
- ☐ Alternating fever and chills
- ☐ Frequent sweating
- ☐ Night sweating
- ☐ Profuse sweating
- ☐ Scant sweating
- ☐ Sweating of specific areas of the body
- ☐ Generalized pain
- ☐ Heavy, tired body
- ☐ Paralysis or numbness
- ☐ Tremors or twitching
- ☐ Generalized itching
- ☐ Jaundice
- ☐ Edema
- ☐ Unusual weight gain or loss
- ☐ Fatigue
- ☐ Drowsiness after eating
- ☐ Afternoon fatigue
- ☐ Bleeding (brusing or hemorrhaging
- ☐ Loss of consciousness
- ☐ Skin diseases

Head and Body

- ☐ Headache
- ☐ Migraines
- ☐ Heavy head sensation
- ☐ Unusual sensations in the head
- ☐ Dizziness or vertigo
- ☐ Dizziness with standing
- ☐ Fine, thin hair
- ☐ Excessive hair loss
- ☐ Premature graying
- ☐ Hot flashes in the head
- ☐ Facial pain
- ☐ Facial numbness or tic
- ☐ Facial swelling
- ☐ Deviated mouth and eyes
- ☐ Shoulder pain
- ☐ Frozen shoulder
- ☐ Arm pain
- ☐ Upper back pain
- ☐ Spinal column pain
- ☐ Lower back pain
- ☐ Tailbone pain
- ☐ Pain of the four limbs
- ☐ Numbness of the limbs
- ☐ Weak limbs
- ☐ Cold limbs
- ☐ Cold hands and feet
- ☐ Joint pain
- ☐ Inhibited stretching
- ☐ Inability to turn neck
- ☐ Stiff neck
- ☐ Neck pain
- ☐ Finger pain
- ☐ Finger numbness
- ☐ Hand tremors
- ☐ Pale, discolored, thick or deformed fingernails
- ☐ Knee pain and swelling
- ☐ Edema of the lower limbs
- ☐ Inflammation of the lower limbs
- ☐ Variscosities of the lower limbs
- ☐ Foot pain
- ☐ Foot or leg tremors

Urogenital

- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Inability to ejaculate
- ☐ Pain, itching, or discomfort of the penis or testicles
- ☐ Pain with urination
- ☐ Profuse urination
- ☐ Frequent urination
- ☐ Frequent urination at night
- ☐ Dribbling urination
- ☐ Bedwetting
- ☐ Incontinence
- ☐ Lack of urination or difficult urination
- ☐ Bloody urine
- ☐ Cloudy urine
- ☐ Soft, loose stools
- ☐ Diarrhea
- ☐ Dysentery
- ☐ Constipation
- ☐ Bloody stools
- ☐ Anal itching
- ☐ Rectal prolapse
- ☐ Anal fissures
- ☐ Hemorroids

Drink, Food, and Taste

- ☐ Unusual taste in mouth (i.e. bitter)
- ☐ Bad breath
- ☐ Excessive saliva
- ☐ Mouth sores
- ☐ Cracked, dry lips
- ☐ Lip tremors
- ☐ Tongue disorders

Craving for (flavors): _____

Food, Drink, and Taste

- ☐ Loose teeth or toothache
- ☐ Extensive dental decay
- ☐ Grinding of the teeth
- ☐ Painful, swollen, or bleeding gums
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Indigestion
- ☐ Hiccup
- ☐ Belching
- ☐ Acid regurgitation
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood

Chest, Rib-side, Stomach, and Abdomen

- ☐ Chest pain
- ☐ Chest tightness
- ☐ Heat or unusual sweating of the chest
- ☐ Cough
- ☐ Coughing of blood
- ☐ Rapid, labored, hasty breathing
- ☐ Wheezing
- ☐ Shortness of breath when speaking
- ☐ Rapid beating of the heart
- ☐ Pains along the sides of the trunk
- ☐ Unusual armpit odor
- ☐ Difficulty swallowing
- ☐ Frequent yawning
- ☐ Stomach pain
- ☐ Burning stomach pain
- ☐ Pain in the area of the navel
- ☐ Abdominal fullness
- ☐ Abdominal swelling (ascites)
- ☐ Lower abdominal pain
- ☐ Rumbling intestines

Thirst and Intake of Beverages

- ☐ Thirst
- ☐ Dry mouth
- ☐ Lack of thirst
- ☐ Thirst unquenched by drinking
- ☐ Drinking without desire to swallow
- ☐ Liking for cold drinks
- ☐ Liking for warm drinks

Eyes, Ears, Nose, and Throat

- ☐ Eye pain
- ☐ Itchy or dry eyes
- ☐ Red eyes
- ☐ Frequent tearing
- ☐ Sensitivity to light
- ☐ Frequent floaters in the visual field
- ☐ Night blindness
- ☐ Impaired vision
- ☐ Blindness
- ☐ Sty
- ☐ Swollen or drooping eyelids
- ☐ Ear ringing
- ☐ Itchy or painful ears
- ☐ Discharge from the ears
- ☐ Hearing impairment
- ☐ Nose pain
- ☐ Nosebleed
- ☐ Dry nose
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Nasal swelling
- ☐ Loss of sense of smell
- ☐ Sore, swollen throat
- ☐ Itchy or dry throat
- ☐ Hoarse voice
- ☐ Loss of voice
- ☐ Sense of a mass stuck in the throat without eating

Sleep

- ☐ Insomnia
- ☐ Difficulty falling asleep
- ☐ Easily being awakened
- ☐ Waking too early
- ☐ Profuse dreaming
- ☐ Excessive sleep

Women

Ages at first and last menses _____

Duration between menses _____

Color, quality, and quantity of bleeding _____

- ☐ Menses sometimes early, sometimes late
- ☐ Clotted menstrual blood
- ☐ PMT (PMS)
- ☐ Pain with menses

Vaginal discharge quality _____

Pregnancies _____

Births _____

Miscarriages _____

Abortions _____

Mental-Emotional

- ☐ Panic attacks
- ☐ Agitation
- ☐ Cognitive impairment
- ☐ Poor memory
- ☐ Impaired speech
- ☐ Depression
- ☐ Easy anger
- ☐ Nervous laughter
- ☐ Anxiety
- ☐ Obsessive thoughts
- ☐ Persistent sorrow
- ☐ Frequently fearful
- ☐ Easily startled

Additional Personal Medical History

- ☐ Abuse survivor
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Birth trauma
- ☐ Blood clots
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Cataracts
- ☐ Changes in libido
- ☐ Chicken pox
- ☐ Concussions
- ☐ Considered/attempted suicide
- ☐ COPD
- ☐ Dandruff
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Excess phlegm
- ☐ Enlarged thyroid
- ☐ Fungal infections
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ Kidney stones
- ☐ Laxative use
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Muscle cramps
- ☐ Neurological disease
- ☐ Phlebitis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Seizures
- ☐ STD's
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid
- ☐ Ulcers
- ☐ Valley fever
- ☐ Whooping cough

Other: _____

Family Medical History

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Mental disorder
- ☐ Neurological disorder
- ☐ Seizures
- ☐ Stroke

Other: _____

Thank you for your assistance and patience.
Enjoy your treatment!