CORE ESSENCE
ACUPUNCTURE & MASSAGE

Health History Questionnaire

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 questions, please ask. If there is anything you wish to bring to our attention, which is not included in this form, please note it in the comments section or speak to us about it. Thank you.

Name: _____Home Phone: _____Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Employer: _____

Date of Birth:_____ Age: _____ Height: _____ Weight: _____

Gender: _____ Martial Status: _____ Insurance Company: _____

Emergency Contact Name: _____ Phone: _____

Physician Name: _____ Phone: _____

Have you had acupuncture before: Yes _____ No_____ // Have you had massage before: Yes _____No_____

How did you hear about us: _____

Significant health history complications in the family (other than yourself): _____

_____

What is the main problem(s) you would like help with today & when did it start?

List in order of importance, and give approximate dates:

1. _____

2. _____

3. _____

What therapies have you tried?

_____

Is your condition getting: Better _____ Worse _____Comes & Goes _____ Same_____

What makes it better? _____

What makes it worse? _____

Current Medications/Supplements: _____

_____

_____

Allergies: _____

Surgery, Trauma, Scars: _____

Lifestyle
- ☐ Yoga
- ☐ Meditation
- ☐ Prayer
- ☐ Coffee
- ☐ Tea
- ☐ Gym Membership
- ☐ Outdoor Activities
- ☐ Smoking
- ☐ Alcohol
- ☐ Drugs

General
- ☐ Chills / Fevers
- ☐ Sweats Easily Without Exertion
- ☐ Night Sweats
- ☐ Bleed or Bruise Easily
- ☐ Preference for Hot Drinks
- ☐ Preference for Cold Drinks
- ☐ No Thirst
- ☐ Fatigue
- ☐ Edema
- ☐ Diabetes
- ☐ Hard to Fall Asleep
- ☐ Hard to Stay Asleep
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Allergies
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Viral Infection
- ☐ Bacterial Infection
- ☐ Fungal Infection
- ☐ Parasites
- ☐ Autoimmune Condition
- ☐ Mold
- ☐ Chemical Sensitivity
- ☐ Thyroid Disorder
- ☐ Childhood Vaccinations
- ☐ Adult Vaccinations
- ☐ Metal Implants
- ☐ Blood Thinning Medications

Skin & Hair
- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives
- ☐ Dry Skin
- ☐ Loss Of Hair
- ☐ Other

Eyes, Ears, Nose & Throat
- ☐ Dry Eyes
- ☐ Watery Eyes
- ☐ Blurry Vision
- ☐ Eye Pain
- ☐ Itchy Eyes
- ☐ Red Eyes
- ☐ Decreased Night Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Discharge From Eyes
- ☐ Poor Hearing
- ☐ Hearing Aids
- ☐ Ringing In The Ears
- ☐ Dizziness
- ☐ Earache
- ☐ Ear Discharge
- ☐ Grinding Teeth
- ☐ Jaw Clicking
- ☐ Teeth Problems
- ☐ Recurrent Sore Throat
- ☐ Sores In Mouth
- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Facial Pain
- ☐ Other

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Tachycardia
- ☐ Bradycardia
- ☐ Chest Pain / Discomfort
- ☐ Cold Hands or Feet
- ☐ Swelling In Feet
- ☐ Blood Clots
- ☐ Fainting
- ☐ Other

Respiratory
- ☐ Cough
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Production of Phlegm
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Other

Gastrointestinal
- ☐ Crave Salty Food
- ☐ Crave Sweet Food
- ☐ Crave Sour Food
- ☐ Change In Appetite
- ☐ Bad Breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Belching
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incomplete Bowel Movement
- ☐ Blood in Stool
- ☐ Mucous in Stool
- ☐ Undigested Food in Stool
- ☐ Hemorrhoids
- ☐ Laxative Use
- ☐ Rectal Pain
- ☐ Gas
- ☐ Bloating
- ☐ Ulcers
- ☐ Indigestion
- ☐ Food Allergies
- ☐ Other

Genitourinary
- ☐ Pain On Urination
- ☐ Urgency To Urinate
- ☐ Frequent Urination
- ☐ Unable To Hold Urine
- ☐ Blood In Urine
- ☐ Incomplete Urine
- ☐ Incontinence
- ☐ Dribbling
- ☐ Decrease In Flow
- ☐ Kidney Stones
- ☐ Waking at Night to Urinate
- ☐ Peculiar Odor of Urine
- ☐ Peculiar Color of Urine
- ☐ Urinary Tract Infection
- ☐ Sores On Genitals
- ☐ Pain With Intercourse
- ☐ Change in Sexual Drive
- ☐ Impotency
- ☐ Other

Musculoskeletal

- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Lower Back Pain
- ☐ Spinal Pain
- ☐ Elbow Pain
- ☐ Hand/wrist Pain
- ☐ Knee Pain
- ☐ Foot/ankle Pain
- ☐ Hip Pain
- ☐ Leg Pain
- ☐ Joint Pain
- ☐ Bone Pain
- ☐ Muscle Pain
- ☐ Muscle Atrophy / Weakness
- ☐ Muscle Spasms
- ☐ Arthritis
- ☐ Difficulty In Range of Motion

Neuro-Psychological

- ☐ Seizures
- ☐ Epilepsy
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Headaches / Migraines
- ☐ Paralysis
- ☐ Stroke
- ☐ Sleep Disorder/Problem
- ☐ Bad Dreams
- ☐ Concussion
- ☐ Tremors
- ☐ Nerve Pain
- ☐ Vertigo
- ☐ Lack Of Coordination
- ☐ Loss Of Balance
- ☐ Poor Memory
- ☐ Depression
- ☐ Fear
- ☐ Anger / Frustration
- ☐ Sadness / Grief
- ☐ Worry / Pensiveness
- ☐ Over-Thinking / Anxiety
- ☐ Irritable
- ☐ Easily Susceptible to Stress
- ☐ Varying Mood Swings
- ☐ Substance Abuse
- ☐ Ever Attempted or Considered Suicide

Women's Health

- ☐ Currently Pregnant (Due Date): _____
- ☐ Number of Pregnancies: ____
- ☐ Number of Births: _____
- ☐ Number of Premature Births:
- ☐ Number of Miscarriages:____
- ☐ Number of Abortions: _____
- ☐ Number of Ectopic Pregnancies: _____
- ☐ Cesarean Births: _____
- ☐ Age At First Menses: _____
- ☐ How Many Days Between Menses: _____
- ☐ Duration of Menses: _____
- ☐ Date of Last Menses: _____
- ☐ Last Pap: _____
- ☐ Heavy Periods
- ☐ Light Periods
- ☐ Painful Periods
- ☐ PMS
- ☐ Clots
- ☐ Bleeding Between Cycles
- ☐ Endometriosis
- ☐ Vaginal Discharge
- ☐ Cysts
- ☐ Hot Flashes
- ☐ Menopause
- ☐ Breast Lumps
- ☐ Nipple Discharge
- ☐ Birth Control
- ☐ Fertility Complications
- ☐ Hormone Replacement Therapy
- ☐ PCOS
- ☐ PID
- ☐ Cancer
- ☐ STD
- ☐ Other

Men's Health

- ☐ Erectile Dysfunction
- ☐ Prostate Cancer
- ☐ Prostate Enlargement
- ☐ Penile Discharge
- ☐ Premature Ejaculation
- ☐ STD
- ☐ Other

Additional Comments:

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