# Health History Questionnaire

Patient Name: ____________________________________________Date: _________

Gender: ____________ Age: ___________ Date of Birth: ______________________

Address: ______________________________________________________________

City: _______________________ State: ________________________ Zip: _________

Home Phone: ________________________ Cell Phone: _______________________

Email: __________________________________ Can We Text you to confirm appts? _____

Occupation: ____________________________ Employer: _____________________

Hours worked per week: ______________ Best Appointment Days & Time _____________

How did you hear about the office? ____________________________________________

| **Chief Complaints**: | **Age or Year: (When it Started)** |
|---|---|
| 1.____________________________________________________ | _________________ |
| 2. ____________________________________________________ | _________________ |
| 3. ____________________________________________________ | _________________ |
| 4.____________________________________________________ | _________________ |
| 5. ____________________________________________________ | _________________ |
| 6 ____________________________________________________ | _________________ |

| **Medications taken** ***Current*** | **For what Reason** | **Start date & How long** |
|---|---|---|
| 1. ____________________ | ______________________ | ______________ |
| 2. ____________________ | ______________________ | ______________ |
| 3. ____________________ | ______________________ | ______________ |
| 4. ____________________ | ______________________ | ______________ |
| 5. ____________________ | ______________________ | ______________ |
| 6. ____________________ | ______________________ | ______________ |
| 7. ____________________ | ______________________ | ______________ |
| 8. ____________________ | ______________________ | ______________ |

Supplements:

| | |
|---|---|
| 1. ________________________ | 4. ____________________________ |
| 2. ________________________ | 5. ____________________________ |
| 3. ________________________ | 6. ____________________________ |

Married? Y/N, How long? _____, Is your current family supportive? Y//N

Children, Age, additional information:__________________________________

## #1: Major Complaint:

______________________________________________________________________

______________________________________________________________________

**When did it First start**? ____________________**How often does it occur**? ______________________________

**Scale: ___/10**, **Quality?** ______________________________________________________________________

**What Triggers it?** ______________________________________________________________________

**What Makes it worse?** ______________________________________________________________________

**What makes it better?** ______________________________________________________________________

**What have you tried? (supplements, herbs, massage, etc)** ____________________________________________

---

## #2: Major Complaint:

______________________________________________________________________

______________________________________________________________________

**When did it First start**? ____________________**How often does it occur**? ______________________________

**Scale: ___/10**, **Quality?** ______________________________________________________________________

**What Triggers it?** ______________________________________________________________________

**What Makes it worse?** ______________________________________________________________________

**What makes it better?** ______________________________________________________________________

**What have you tried? (supplements, herbs, massage, etc)** ____________________________________________

## #3: Major Complaint:

______________________________________________________________________________

______________________________________________________________________________

When did it First start? ________________How often does it occur? _________________________

Scale: ___/10, Quality? ________________________________________________________

What Triggers it? ________________________________________________________________

What Makes it worse? _____________________________________________________________

What makes it better? _____________________________________________________________

What have you tried? (supplements, herbs, massage, etc) _____________________________________

---

## #4: Major Complaint:

______________________________________________________________________________

______________________________________________________________________________

When did it First start? ________________How often does it occur? _________________________

Scale: ___/10, Quality? ________________________________________________________

What Triggers it? ________________________________________________________________

What Makes it worse? _____________________________________________________________

What makes it better? _____________________________________________________________

What have you tried? (supplements, herbs, massage, etc) _____________________________________

**Review of Symptoms**

General: ______________________________________________________________________

Ears, Eyes, Nose, Throat_______________________________________________________________

Immune/Allergies: ______________________________________________________________

Cardio/Vascular:_________________________________________________________________

Gastro/Digestion (GERD, Indigestion?)__________________________________________________

Urinary(color, frequency)______________________________________________________________

Bowels (How often? Formed? Loose?) _________________________________________________

Menses(Regular? PMS symptoms?)_____________________________________________________

Sleep (How often do you wake up? Difficulty falling asleep? Difficulty staying asleep?):

_________________________________________________________________________________

Energy: ______________________________________________________________________

Pain: ________________________________________________________________________

Mental/Mood:__________________________________________________________________

Current Diet (Fast food? Organic?)_______________________________________________________

Current Exercise: ______________________________________________________________

Current Mind-Body Spirit Practice: _____________________________________________________

How does your current health issues affect your life: work, relationships, extracurricular activity?

_________________________________________________________________________________

How committed are you to getting your health under control (1-10): ____________

Is there anything that would prevent you from treatment? ________________________________________

What have you heard about Acupuncture? ___________________________________________

**Previous Long term/Chronic Illnesses**: (List in ***Date Order of Occurrence***)

| Age/ Year | Illness/Sickness | Medical Diagnoses | Medical treatment | Medications | Natural Protocols used |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PHYSICAL STRESSORS** (List in ***Date Order of Occurrence***)

| **Age/ Year** | **Car Accidents** | **Falls/Trips Sports injuries** | **Broken Bones** | **Surgeries** Dental surgery Births, abortions | **Scars/Stitches** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## CHEMICAL STRESSORS (List in ***Date Order of Occurrence***)

| **Age/Year** | **Toxin Exposures** (Metals, Chemicals, Radiation, Pesticides, Mold, GMO's) | **OLD Medications** Long Term use: over 1 year | **Alcohol/ Smoking /Street Drugs** | **Dental** Fillings, crowns, cavities | **OTHER** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**EMOTIONAL/Psychological STRESSORS** (List in Date order of occurrence)
***Significant Emotional traumas: Death in family, Divorce, Job, significant stressors, etc***

| | |
|---|---|
| **How was childhood? Age 0 – 12** | |
| **Teenage years** | |
| **Adulthood** | |
| **Relationship with Mother** | |
| **Relationship with Father** | |
| **Work/Finances** | |
| **Marital Relationship:** | |
| **Children** | |
| **Other** | |

**The combination of physical, chemical and psychological stress on the body over a lifetime *leads to imbalances* in the mind-body-spirit over time. This long-standing imbalance *leads to symptoms* and eventually *disease*. It is my job to find where these imbalances are in your body and based on your specific needs develop a plan to correct them.**

***Please email your completed form to: DrRose.Honor@gmail.com***