NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Dear New Patient:

a. Please **read** and **fill in** all of the information that pertains to you.
b. On pages 2 through 11, under each category, **check all** symptoms that you experience either *acutely or chronically* .
c. **Add** and **total** all of the boxes you checked.
d. **Date** today's day.

	TEST	*DATE*	*TEST RESULTS*
☐	Physical	_______	____________________
☐	Cholesterol	_______	____________________
☐	Prostate	_______	____________________
☐	Mammography	_______	____________________
☐	Pap Smear	_______	____________________
☐	Blood (which test?)	_______	____________________
☐	HIV/STD	_______	____________________
☐	Other	_______	____________________

Please indicate if you have (or have been tested for) any of the following:			
☐ Diabetes	☐ Allergies	☐ Rheumatic Fever	☐ Vein Condition
☐ Heart Disease	☐ CVA (stroke)	☐ Thyroid Disorder	☐ Tuberculosis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Chicken Pox
☐ High Blood Pressure	☐ Gonnorhea	☐ Bleeding Tendency	☐ Polio
☐ Syphilis	☐ Measles	☐ Nervous Disorder	☐ Migraines
☐ Meningitis	☐ HIV	☐ Monoucleosis	☐ Other Liver Illnesses
☐ Epilepsy	☐ High Fever	☐ Multiple Sclerosis	☐ Other Heart Illnesses
☐ Paralysis	☐ Cancer	☐ Jaundice	☐ Other Kidney Illnesses
☐ Glaucoma	☐ Mumps	☐ Hepatitis	☐ Other Lung Illnesses

IMMUNIZATIONS?
____
____
____
____
____

SURGERIES?
____
____
____
____
____

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

1. Pain:

On the figures below, please mark clearly any areas of pain and indicate any scars.

	What makes the pain better?
☐	Soft Preassure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Rest
☐	Other

	What makes the pain worse?
☐	Soft Pressure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Other

2. Describe your pain:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Sharp	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Fixed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Moving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Cramping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Aching	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Dull	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Other:________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	***Total Boxes Checked***	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Date:_____________ RE Date:	/	/	/	/	/	/	/	/	/	/	/	/

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

3. *Kidney Function:*
(Overall Temperature)

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Cold Hands												
☐ Cold Fingers												
☐ Cold Toes												
☐ Cold Feet												
☐ Sweaty Hands												
☐ Sweaty Feet												
☐ Hot Body Temperature Sensation												
☐ Cold Body Temperature Sensation												
☐ Afternoon Flushes												
☐ Night Sweats												
☐ Heat in the hands, feet & chest												
☐ Hot flashes any time of the day												
☐ Thirsty												
☐ Perspire easily												
☐ Lack of perspiration												
☐ Do you take water to bed												
☐ ***Total Boxes Checked***												
Date:_____________ RE Date:												

4. *Lung, Kidney Function:*
(Overall Energy)

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Shortness of Breath												
☐ Difficulty keeping eyes open (daytime)												
☐ General Weakness												
☐ Easily catch colds												
☐ Low Energy												
☐ Feel worse after exercise												
☐ Chronic (daily) fatigue & malaise												
☐ ***Total Boxes Checked***												
Date:_____________ RE Date:												

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

5. Liver, Spleen, Heart Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Dizziness												
☐ See floating black spots												
☐ ***Total Boxes Checked***												
Date:_____________ RE Date:												

6. Heart Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Anxiety												
☐ Sores on tip of tongue												
☐ Restlessness												
☐ Mental confusion												
☐ Chest pain traveling to shoulder												
☐ Frequent dreams												
☐ Wake unrefreshed												
☐ Coffee? How much per week?_______												
☐ ***Total Boxes Checked***												
Date:_____________ RE Date:												

7. Spleen Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Low Appetite												
☐ Abrupt Weight Gain												
☐ Abrupt Weight Loss												
☐ Abdominal Bloating												
☐ Abdominal Gas												

spleen function continued next page...

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

7. Spleen Function, continued…

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Gurgling noise in Stomach												
☐	Fatigue after eating												
☐	Prolapsed Organs? Which?_________												
☐	Bruise easily?												
☐	Over-Thinking												
☐	Worry												
☐	***Total Boxes Checked***												

Date:_____________ RE Date:

8. Lung Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Nasal Discharge (color___________)												
☐	Cough												
☐	Nose Bleeds												
☐	Sinus Congestion												
☐	Dry Mouth												
☐	Dry Throat												
☐	Dry Nose												
☐	Dry Skin												
☐	Allergies (what?_________________)												
☐	Alternating Chills/Fever												
☐	Sneezing												
☐	Headache (location______________)												
☐	Overall achy feeling in body												
☐	Stiff Neck												
☐	Stiff Shoulders												
☐	Sore Throat												
☐	Difficulty breathing												
☐	Smoke cigarettes (# per day_______)												
☐	Sadness												
☐	Melancholy												
☐	***Total Boxes Checked***												

Date:_____________ RE Date:

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

9. Spleen, Stomach, Small/Large Intestine Function

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Loose Stools												
☐	Constipated												
☐	Incomplete Stools												
☐	Diarrhea												
☐	Blood in Stools												
☐	Mucous in Stools												
☐	Undigested food in the Stools												
☐	***Total Boxes Checked***												
	Date:_____________ RE Date:												

10. Stomach Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Burning sensation after eating												
☐	Large appetite												
☐	Bad Breath												
☐	Canker Sores (mouth)												
☐	Bleeding, swollen or painful gums												
☐	Heartburn												
☐	Acid Regurgitation												
☐	Ulcer (diagnosed?)												
☐	Belching												
☐	Hiccups												
☐	Stomach Pain												
☐	Vomiting												
☐	***Total Boxes Checked***												
	Date:_____________ RE Date:												

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

11. Dampness trapped in the Body:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Bodily sensation of heaviness												
☐ Mental heaviness												
☐ Mental sluggishness												
☐ Mental fogginess												
☐ Swollen hands												
☐ Swollen feet												
☐ Swollen joints												
☐ Chest congestion												
☐ Nausea												
☐ Snoring												
☐ ***Total Boxes Checked***												
Date:_____________ RE Date:												

12. Liver Function (eyes):

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Itchy												
☐ Bloodshot												
☐ Hot												
☐ Dry												
☐ Watery												
☐ Gritty												
☐ Blurry Vision												
☐ Decreased Night Vision												
☐ Near-sighted												
☐ Far-sighted												
☐ ***Total Boxes Checked***												
Date:_____________ RE Date:												

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

13. Liver, Gall Bladder Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12

- Alternating Diarrhea & Constipation
- Chest Pain
- Tight sensation in the Chest
- Bitter taste in the mouth
- Anger easily
- Depression
- Frustration
- Irritability
- Skin Rashes
- Headache at the top of the Head
- Tingling Sensation
- Numbness
- Muscle twitching
- Muscle cramping
- Muscle Spasms
- Seizures
- Convulsions
- Lump in the throat
- Neck Tension
- Shoulder Tension
- Limited Range-of-Motion (Neck)
- Limited Range-of-Motion (Shoulder)
- How much Alcohol / day?__________
- Recreational drugs (which?__________)
- High-pitched Ringing in Ears
- Gallstones (history or current)
- STD's (which?__________________)
- Unable to adapt to Stress

Total Boxes Checked

Date:_____________ RE Date:

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

14. Kidney, Urinary Bladder Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Frequent cavities, teeth problems												
☐	Easily broken bones												
☐	Sore knees												
☐	Weak knees												
☐	Cold sensation in the knees												
☐	Low Back Pain												
☐	Memory problems												
☐	Excessive hair loss												
☐	Low-pitched ringing in the ears												
☐	Kidney Stones												
☐	Bladder Infections												
☐	Lack of bladder control												
☐	Wake during the night 2 (or more) times to urinate?												
☐	Fear												
☐	Easily startled												
☐	***Total Boxes Checked***												

Date:_____________ RE Date:

15. Libido:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Normal												
☐	High												
☐	Low												
☐	***Total Boxes Checked***												

Date:_____________ RE Date:

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

16. Urination (Bladder Function):

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
Color (please check):												
☐ Pale____; Dk Yellow____; Clear____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Reddish	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Cloudy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Scanty	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Profuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Strong Oder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Painful	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Discharge	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Difficult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Urgent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Frequent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked***	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:____________ RE Date:												

WOMEN ONLY

☐ Yes ☐ No Do you have a regular menstrual cycle?
☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Do you have bleeding beetween periods?
☐ Yes ☐ No Do you have a vaginal discharge?

_______ Age of first menstruation
_______ Average number of days in flow
_______ Average number of days in entire cycle
_______ Number of children
_______ Number of pregnancies
_______ Age of menopause (if applicable)

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (choose one): normal, pale, bright red, brown rust, dark purple, other	________	________	________	________	________	________	________
Amount of flow (choose one): normal, heavy, light	________	________	________	________	________	________	________
Pain/Cramps (choose one): dull, sharp, other	________	________	________	________	________	________	________
Vomiting (check if yes):	________	________	________	________	________	________	________
Nausea (check if yes):	________	________	________	________	________	________	________

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Women Only:

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	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Nausea												
☐	Vomiting												
☐	Food cravings												
☐	Water retention												
☐	Breast swelling												
☐	Breast tenderness												
☐	Headaches												
☐	Migraines												
☐	Dull pain (where?__________)												
☐	Sharp pain (where?___________)												
☐	Depression												
☐	Irritability												
☐	Anxiety												
☐	Other (explain_____________)												
☐	***Total Boxes Checked***												
	Date:_____________ RE Date:												

Men Only:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Swollen testes												
☐	Testicular pain												
☐	Impotence												
☐	Premature ejaculation												
☐	Feeling of coldness or Numbnesss in external genitalia												
☐	Other?												
☐	***Total Boxes Checked***												
	Date:_____________ RE Date:												

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