

# **Newport Acupuncture & Herbal Medicine**

## Health History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Marital Status: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Previous Acupuncture Care? \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Optimal health can be achieved! At Newport Acupuncture, we believe that disease prevention and optimal health are a possibility for everyone. By getting to know you, we can help you in achieving your health goals. We would like to be your guide in learning how use Chinese medicine as a tool in leading a healthier and more enjoyable life. Please take your time in answering these questions. If you have any questions, do not hesitate to ask.

**Reason for your visit today:** \_\_\_\_\_  
\_\_\_\_\_

**Secondary reason(s):** \_\_\_\_\_  
\_\_\_\_\_

As a result of my acupuncture care, I would like to:

- Get better quickly  Achieve optimal health and well-being  
 Lead a healthier life  All of the above

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Upon your second visit to Newport Acupuncture, you will receive our Report of Findings. This report will include our assessment of your condition based on the principles of Traditional Chinese Medicine (TCM). As Doctors of Acupuncture, we encourage you to seek appropriate treatment and care from your physicians. We believe the combination of TCM and treatments you have agreed upon with your physician will generally provide the best long-term results. If you choose to use TCM as an alternative to any physician prescribed treatment plan, please discuss this with your physician prior to your first visit.

### **Surgeries and Hospitalizations**

\_\_\_\_\_  
\_\_\_\_\_

### **Current Medications/Herbs/Vitamins**

\_\_\_\_\_  
\_\_\_\_\_

### **Significant Trauma (accidents, falls, etc)**

\_\_\_\_\_  
\_\_\_\_\_

**Diet** Meals per day: \_\_\_\_\_ Snacks per day: \_\_\_\_\_ Caffeinated drinks per day: \_\_\_\_\_ Alcohol per week: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Exercise** Days per week: \_\_\_\_\_ Duration of work out: \_\_\_\_\_

Types of Exercise: \_\_\_\_\_

**BY SIGNING BELOW, I AM CONFIRMING THAT I UNDERSTAND THE CURRENT REFERRAL POLICY OF NEWPORT ACUPUNCTURE AND HERBAL MEDICINE.**

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Your Medical History** (Please check any of the following conditions you currently have or have had in the past):

- |                                       |  |   |  |  |
|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV     | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Measles           |
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Thyroid Disorders   | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gout          | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid Fever       | <input type="checkbox"/> Whooping cough    |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Polio              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Herpes        | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Scarlet Fever       | <input type="checkbox"/>                   |

**General Symptoms:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Poor appetite           | <input type="checkbox"/> Lack of strength        | <input type="checkbox"/> Night sweats           | <input type="checkbox"/> Fever              |
| <input type="checkbox"/> Heavy appetite          | <input type="checkbox"/> Bodily heaviness        | <input type="checkbox"/> Muscle cramps          | <input type="checkbox"/> Chills             |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Vertigo or dizziness   | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Poor sleep              | <input type="checkbox"/> Peculiar taste in mouth | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Poor circulation   |
| <input type="checkbox"/> Heavy sleep             | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Dream disturbed sleep  | <input type="checkbox"/>                    |

**Head, Eyes, Ears, Nose & Throat:**

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Glasses       | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> Night Blindness         | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Eye strain    | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Sensitive to light      | <input type="checkbox"/> Excessive phlegm      | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Eye pain      | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Red eyes      | <input type="checkbox"/> TMJ            | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Concussions     |
| <input type="checkbox"/> Itchy eyes    | <input type="checkbox"/> Facial pain    | <input type="checkbox"/> Dry mouth               | <input type="checkbox"/> Lumps in throat       | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Gum problems   | <input type="checkbox"/> Excessive saliva        | <input type="checkbox"/> Enlarged thyroid      | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Nose bleeds   |   |  |  |  |

**Respiratory:**

- |   |  |                                 |   |
|---|--|---------------------------------|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tight chest     | <input type="checkbox"/> Cough  | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Pneumonia      |

**Cardiovascular:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Fast heart rate    | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Heart palpitations |  |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Phlebitis          |  |

**Musculo-Skeletal:**

- |   |  |                                     |  |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> Neck/Shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion |
| <input type="checkbox"/> Muscle pain        | <input type="checkbox"/> Low back pain   | <input type="checkbox"/> Rib pain   | <input type="checkbox"/> Other                   |

**Skin and Hair:**

- |                                       |                                   |   |                                |
|---------------------------------------|-----------------------------------|---|--------------------------------|
| <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Acne     | <input type="checkbox"/> Hair loss              | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ulcerations  | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal infections      |                                |
| <input type="checkbox"/> Psoriasis    | <input type="checkbox"/> Itching  | <input type="checkbox"/> Change in skin texture |                                |

**Neuropsychological:**

- |                                   |                                      |  |   |
|-----------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Considered Suicide |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression  | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Tics     | <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Abuse survivor  | <input type="checkbox"/> Other              |

**Genitourinary:**

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Increased libido      | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Bedwetting      |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incomplete urine     | <input type="checkbox"/> Decreased libido      | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Urgent urination   | <input type="checkbox"/> Venereal disease     | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Impotence          | <input type="checkbox"/>                 |
| <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Urinary infection    | <input type="checkbox"/>                       | <input type="checkbox"/>                    | <input type="checkbox"/>                 |

**Digestion:**

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Painful digestion | <input type="checkbox"/> Loose stools | <input type="checkbox"/> Weight gain  |
| <input type="checkbox"/> Bloating          | <input type="checkbox"/> Hard stools  | <input type="checkbox"/> Gas/Belching |

**Obstetrics-Gynecology**

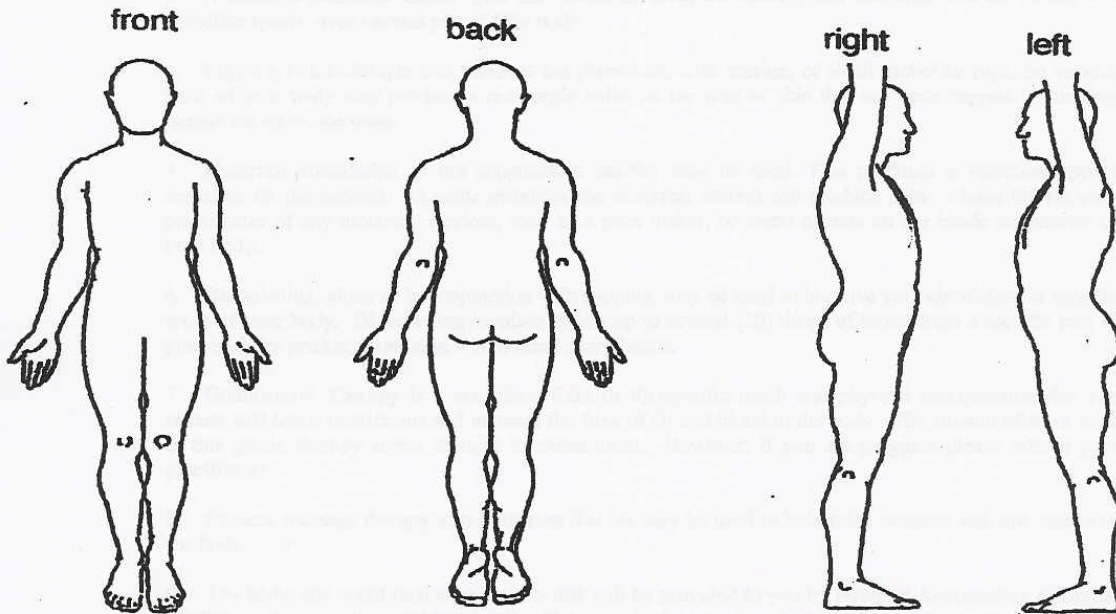
- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> # of pregnancies | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> Painful periods   | <input type="checkbox"/> Vaginal odor  | _____                                     |   |
| <input type="checkbox"/> PMS               | <input type="checkbox"/> Clots         | <input type="checkbox"/> # of live births |   |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast lumps  | _____                                     |   |

**Other** (if you need more room, please feel free to attach another page)

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## BODY MAP

Please circle any areas that are sore and/or painful and describe in detail on the lines below the nature of the pain.



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