Joyce Greenberg, L.Ac.
Acupuncturist
10216 63RD AVE. SO., SEATTLE, WA 98178
206.760.4828 • WWW.JOYCEGREENBERG.COM

Many factors must be considered in designing a complete health-building program. Treating the whole person requires attention to all symptoms and conditions. Often minor symptoms are major clues to delicate somatic imbalances. Please complete the questionnaire as carefully as you can. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized me to do so.

Health History Questionnaire

Date ______________________

Name	
Address	
Home Phone	Work Phone
Date of Birth Age	Occupation
Height Weight	Family Physician
Referred By	e-mail address:

What is/are the main problem/s you would like me to help you with?

When did it begin? (Date)_____________Describe what caused it:

To what extent does this problem interfere with your daily activities (work, sleep, sex)?

Have you been given a diagnosis for this problem? If so, what?

Have you been advised to have any surgery which was not done?

What kinds of treatment/medicine have you tried?

Past Medical History (please include date)

Cancer ______________ High Blood Pressure _______ Thyroid Disease ________
Jaundice________ Diabetes _________________________ Heart Disease _____________
Seizures ______________Pneumonia_______ Hepatitis _________ Rheumatic Fever_____
Venereal Disease _______ TB_____________

Other ____

Surgeries (type and date):

Significant Trauma (physical or emotional -auto accidents, falls, divorce, death in family, abuse etc.) **Include date**.

Significant Dental Work (type and date):

Birth History (prolonged labor, forceps delivery, etc.):

Allergies (drugs, chemicals, foods/result):

Family Medical History	Diabetes	High Blood Pressure	Stroke	Asthma
	Cancer	Heart Disease	Seizures	Allergies
	Other			

Medicines taken within the last two months (medications, vitamins, herbs, etc):

Occupational Stress (chemical, physical, psychological, etc.):

Do you have a regular exercise program? Yes No
Please describe________________________________

Please describe the emotions or mind states (examples: anger, fear, grief, sadness, joy, over thinking, frustration, etc) that seem predominant in your life (frequently experienced, difficult to express or overcome, or in any way influential).

Have you ever been on a restricted diet? Yes No
What kind and when?____
Any peculiar taste in mouth___________________________________
Any particular food cravings__________________________________

Please describe your last three meals:

Morning ____

Afternoon____Snacks______________

Evening____

____Snacks______________________

How many packs of cigarettes do you smoke per day? _________
How much alcohol do you drink per day?______________
How much coffee, tea or cola do you drink per day? _________

Please check any symptoms you have had in the last three months:

General

Chills
Fevers
Sweat easily
Night sweats
Localized weakness
Bleed or bruise easily
Peculiar tastes or smells
Strong thirst (cold or hot)
Thirst, no desire to drink
Fatigue
Sudden energy drop
Time of day?
____
Edema Where?
____
Poor sleeping
Tremors
Poor balance
Cravings
Change in appetite
Poor appetite
Weight gain
Weight loss

Skin and Hair

Rashes
Itching
Change in hair or skin
Ulcerations
Eczema
Oozing or skin lesion
Hives
Pimples
Recent moles
Loss of hair
Dandruff
Other hair or skin problems:
____

Head, Eyes, Ears, Nose, And Throat

Dizziness
Migraines
Headaches
When: ________________
Where:_________________
Facial Pain
Glasses
Poor vision
Night blindness
Blurry vision
Color blindness
Blind field
Spots in front of eyes
Eye pain
Eye strain
Cataracts
Eye dryness
Excessive tear
Discharge from eyes
Poor hearing
Ringing in ears
Earaches
Discharge from ears
Nose bleeds
Sinus congestion
Nasal drainage
Grinding teeth
Teeth problems
Jaw Clicks
Concussions
Recurrent sore throats
Hoarseness
Sores on lips or tongue
Other head or neck problems:
____
____

Cardiovascular

High blood pressure
Low blood pressure
Chest discomfort/pain
Heart palpitations
Cold hands or feet
Swelling of hands
Swelling of feet
Blood clots
Fainting
Difficulty in breathing
Other heart/vessel problems:
____
____

Blood in stools
Black stools
Abdominal pain or cramps
Gas
Rectal pain
Hemorrhoids
Other stomach or intestinal problems ________________

Genito-Urinary

Pain on urination
Urgency to urinate
Frequent urination
Blood in urine
Decrease in flow
Unable to hold urine
Dribbling
Kidney stones
Impotency
Change of sexual drive
Sores on genitals
Do you wake up to urinate?
Yes No
How often? ____________
Clots
Menopause:
Age ____________
Year ____________
Vaginal discharge
Postcoital bleeding
Vaginal sores
Date of last Pap
____
Breast lumps
Nipple discharge
Do you practice birth control?
Yes No
What type and for how long?
____
____

Musculoskeletal

Neck pain
Shoulder pain
Back pain
Elbow pain
Hand/wrist pain
Hip pain
Knee pain

Respiratory		
Cough Asthma/wheezing Pain with a deep breath Difficulty in breathing when lying down Production of phlegm. What color? _____________ Coughing blood Pneumonia Bronchitis Other lung problems: _________________________	Any particular color to your urine? __________________________ other genital/urinary system problems? __________________________	Foot/ankle pain Muscle pain Muscle weakness
	Pregnancy And Gynecology	**Neuropsychological**
	Number of pregnancies _____ Number of births _____ Number of premature births___ Number of miscarriages_____ Number of abortions ______ Age at first menses _______	Seizures Areas of numbness Weakness Sleep disorder Concussion Bad temper Loss of control/violence potential Vertigo Lack of coordination
Gastrointestinal		
Bad breath Nausea Vomiting Heartburn Belching Indigestion Diarrhea Constipation Chronic laxative use	Days between menses _______ Duration of menses (days) ___ First date of last menses: __________________________ Heavy periods Light periods Painful periods Irregular periods Changes in body/psyche prior to menstruation	Depression Easily susceptible to stress Loss of balance Poor memory Anxiety Substance abuse Seeing a therapist? ________ For how long?____________ Have you ever considered or attempted suicide? _______

Please use the space below to sketch the location and nature of your condition and/or pain (if applicable).