

Sound Garden Healing

Janet Michel, R.N., M.Ac., L.Ac.
(206) 310-3272

Health History Questionnaire

Date ____/____/____

Name:		Social Security Number:	
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Gender:	Age:
Cell Phone:	Height:	Weight:	Date of Birth:
Occupation:	Employers Name:		
Primary Physician:	Referred By:		
Emergency Contact Number:	Emergency Phone Number:		
Have you been treated by acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No		E-mail:	

What is/are the main problem(s) you would like help with: _____

How Severe is your problem now? (Rank on the scale below)

No Problem

Worst Imaginable



Past Medical History: (please include date)

Cancer _____ High Blood Pressure _____ Rheumatic Fever _____ Urinary Tract Infection____
Diabetes _____ Heart Disease _____ Seizures _____ Asthma _____
Hepatitis _____ Stroke _____ Thyroid Disease _____ STD _____
Women only: Any chance of being pregnant? _____
Other: _____

Current Medications (include vitamins, over-the-counter drugs, herbs): _____

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Please Check Any Symptom You Have Had in the Last Three Months. Circle Former Conditions.

<p>General</p> <input type="checkbox"/> Chills <input type="checkbox"/> Fevers <input type="checkbox"/> Sweat easily <input type="checkbox"/> Night sweats <input type="checkbox"/> Localized weakness <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Peculiar tastes or smells <input type="checkbox"/> Strong thirst (cold/hot) <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Fatigue <input type="checkbox"/> Sudden energy drop <i>Time of Day:</i> _____ <input type="checkbox"/> Edema <i>Where:</i> _____ <input type="checkbox"/> Poor sleeping <input type="checkbox"/> Tremors <input type="checkbox"/> Poor Balance <input type="checkbox"/> Cravings <input type="checkbox"/> Change in appetite <input type="checkbox"/> Poor appetite <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	<input type="checkbox"/> Color Blindness <input type="checkbox"/> Blind Field <input type="checkbox"/> Spots in front of eyes <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye strain <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye Dryness <input type="checkbox"/> Excessive tear <input type="checkbox"/> Discharge from eyes <input type="checkbox"/> Poor hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earaches <input type="checkbox"/> Discharge from ear <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Teeth problems <input type="checkbox"/> Jaw clicks <input type="checkbox"/> Concussions <input type="checkbox"/> Recurrent sore throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sores on lips or tongue <i>Other head/neck problems:</i> _____ _____ _____	<p>Gastrointestinal</p> <input type="checkbox"/> Bad breath <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Belching <input type="checkbox"/> Indigestion <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Blood in stool <input type="checkbox"/> Abdominal pain or cramps <input type="checkbox"/> Gas <input type="checkbox"/> Rectal pain <input type="checkbox"/> Hemorrhoids <i>Other stomach/intestinal problems:</i> _____ _____ _____	<input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Changes in body/psyche prior to menstruation <input type="checkbox"/> Clots <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Menopause: <i>Age:</i> _____ <i>Year:</i> _____ <input type="checkbox"/> Postcoital bleeding <input type="checkbox"/> Vaginal sores <input type="checkbox"/> Breast lumps <input type="checkbox"/> Nipple discharge <i>Do you practice birth control?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>What type and for how long?</i> _____ _____
<p>Skin and Hair</p> <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Change in hair or skin <input type="checkbox"/> Ulcerations <input type="checkbox"/> Eczema <input type="checkbox"/> Oozing skin lesions <input type="checkbox"/> Hives <input type="checkbox"/> Pimples <input type="checkbox"/> Recent moles <input type="checkbox"/> Loss of hair <input type="checkbox"/> Dandruff <i>Other hair or skin problems</i> _____ _____ _____	<p>Cardiovascular</p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chest discomfort/pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Swelling of hands <input type="checkbox"/> Swelling of feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty breathing <i>Other heart/blood vessel problems:</i> _____ _____ _____	<p>Genito-Urinary</p> <input type="checkbox"/> Pain when urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Decrease in flow <input type="checkbox"/> Dribbling <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Change in sexual drive <input type="checkbox"/> Sores on genitals <i>Do you wake up to urinate?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>How often?</i> _____ <i>Any particular color to your urine?</i> _____ _____ <i>Other genital/urinary system problems?</i> _____ _____ _____	<p>Musculoskeletal</p> <input type="checkbox"/> Neck pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Back pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Hand/wrist pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <i>Other pain:</i> _____ _____ _____
<p>Head, Eyes, Ears, Nose, and Throat</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches <i>When:</i> _____ <i>Where:</i> _____ <input type="checkbox"/> Facial Pain <input type="checkbox"/> Glasses <input type="checkbox"/> Poor Vision <input type="checkbox"/> Night Blindness <input type="checkbox"/> Blurry vision	<p>Respiratory</p> <input type="checkbox"/> Cough <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Pain with a deep breath <input type="checkbox"/> Difficulty in breathing when lying down <input type="checkbox"/> Phlegm, <i>Color?</i> _____ <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <i>Other lung problems:</i> _____ _____ _____	<p>Pregnancy and Gynecology</p> Number of pregnancies: _____ Number of births: _____ Number of premature births: _____ Number of miscarriages: _____ Number of abortions: _____ Age at first menses: _____ Time between menses (days): _____ Duration of menses (days): _____ First Date of last menses: _____	<p>Neuropsychological</p> <input type="checkbox"/> Seizures <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Concussion <input type="checkbox"/> Violence potential <input type="checkbox"/> Vertigo <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Bad temper <input type="checkbox"/> Depression <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Loss of balance <input type="checkbox"/> Poor memory <input type="checkbox"/> Anxiety <input type="checkbox"/> Substance abuse <i>Have you ever been treated for emotional problems?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No