Huffman Wellness
Acupuncture & Herbal Center
www.huffmanwellness.com

Health History Questionnaire

CONFIDENTIAL

813-831-6080 | 4721 W. Kensington Ave. | Tampa, FL | 33629

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender	Date of Birth	Age	Eye Color:	Height:	Weight:
M **F**	_____ / _____ / _____				

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One*	Phone (Nighttime) # – **Home Work Mobile** *Circle One*	
( )	( )	
Alternate Phone # – **Home Work Mobile** *Circle One*	Place of Employment	Occupation
( )		

Name & Phone Numbers of Partner:	Name & Phone Numbers of Emergency Contact:
Primary ( ) Alternate ( )	Primary ( ) Alternate ( )

E-Mail:

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How did you hear about us? *Please circle one and write the name*

Current Patient: ___________ Doctor: __________ Advertisement: ___________ Friend: ________ Insurance: ____________ Other: ____________

Have you received a Diagnosis for your condition(s)? Y / N If so what:

By Whom:

Have you had Acupuncture before? Y / N

Did you have a positive ☐ Experience ☐ Out come

	Severe	Moderate	Slight	Major Complaint(s), in order of **importance** to you:
1.	☐	☐	☐	______________________________
2.	☐	☐	☐	______________________________
3.	☐	☐	☐	______________________________
4.	☐	☐	☐	______________________________
5.	☐	☐	☐	______________________________

When/how did this condition occur? Give dates if possible. 1) ______________________________

2) ______________________________ 3) ______________________________

How do these conditions impair your daily activities? 1) ______________________________

2) ______________________________ 3) ______________________________

Treatment(s) you have received for this condition: 1) ______________________________

2) ______________________________ 3) ______________________________

What treatments helped the most? 1) _____

2) _____ 3) _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.	**OCCUPATIONAL CONCERNS** Check (√) if your work exposes you to the following:	**DIET & EXERCISE** Check (√) all that apply.
Year	**Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)**		☐ Stress ☐ Environmental ☐ Heavy Typing ☐ Heavy Lifting ☐ Others:	☐ Regular Exercise
				☐ Low-Fat ☐ Low-Carb ☐ Vegetarian ☐ alcohol consumption
				☐ Other:
				☐ Drink Coffee: Cups/Day
			Occupation: _____	☐ Drink Soda oz/Day

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if Not Applicable.

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater
_____ Bad Taste
_____ Bad Breath
_____ Do you Crave: Sour

KIDNEY/ URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Dropped Bladder
_____ Incontinence
_____ Lack of Bladder Control
_____ Weakness/ Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Cold Hands
_____ Cold Feet
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Fear
_____ Hot Flash/ Night Sweating
_____ Do you crave: Salty

Heart / Small Intestine

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life
_____ Do you crave: Bitter

LUNG / LARGE INTESTINE

_____ Bloody Cough
_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge / Circle Color - White Yellow Green
_____ Post Nasal Drip / Circle Color: White Yellow Green
_____ Sinus Infection/ Congestion
_____ Itchy, Red, or Painful Throat
_____ Dry Mouth/ Throat/ Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & goes
_____ Smokes Cigarettes
_____ Emphysema
_____ Bronchitis
_____ Black / Blood in Stools
_____ Constipation
_____ IBS
_____ Colitis/ Spastic Colon
_____ Diarrhea
_____ Do you Crave : Pungent

SPLEEN / STOMACH

_____ Heaviness Anywhere in the Body
_____ Energy on a Scale of 1(**low**) –10 (**high**)
_____ Hard to get up in the Morning
_____ Muscles Feel Tired Often
_____ Edema (swelling) □ hands □ feet
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Difficulty Digesting Fatty Foods
_____ Nausea/ Vomiting
_____ Gas / Belching
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over - Thinking
_____ Tendency to Gain Weight

_____ Low Sex Drive / Libido	_____ Shortness of Breath	_____ Brain Foggy
_____ Excess Sexual Desire	_____ Allergies / Asthma	_____ Do you Crave: Sweet

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 5.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the space below.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Anorexia / Bulimia											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

_____

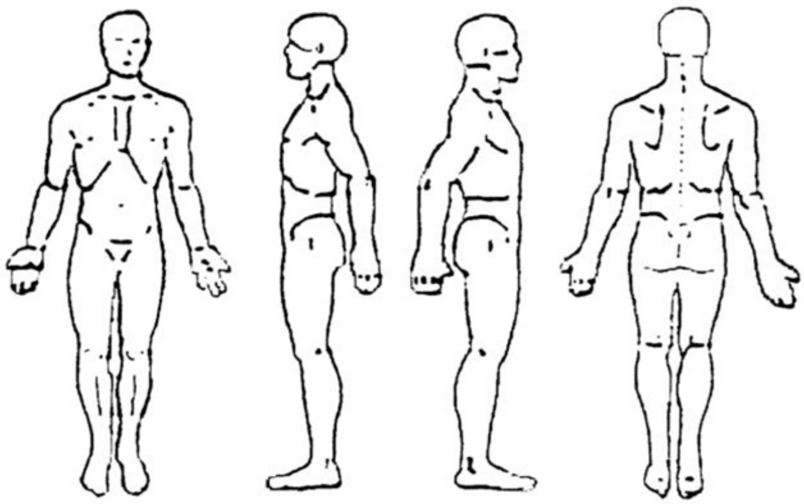
MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

What Makes this Better? : ____________________________________

Please mark problem areas on diagram:



Location of Pain	
Is the Pain	☐ Sharp ☐ Burning ☐ Aching ☐ Fixed ☐ Numbness ☐ Tingling ☐ Other:____________
On a Scale of 1 (Low) – 10 (unbearable):	
Is the Pain Better With:	☐ Rest ☐ Activity ☐ Ice ☐ Heat ☐ Other:____________ ☐ Massage ☐ ☐ Chiropractic

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On a Scale of 1 (Low) – 10 (unbearable):	
Is the Pain Better With:	☐ Rest ☐ Activity ☐ Ice ☐ Heat ☐ Other:____________ ☐ Massage ☐ ☐ Chiropractic

Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No
Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period start? _____

Number of days for menstrual cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:
☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:
☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:
☐ None ☐ IUD ☐ Birth Control Pills
☐ Spermicides ☐ Barriers

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*
- ☐ Cramping in Low Back
- ☐ In Groin Area
- ☐ Moderate
- ☐ Severe
- ☐ Before Period
- ☐ Mild
- ☐ Do you feel Ovulation
- ☐ During Period
- ☐ After Period
- ☐ Do you us pain Medication? What Kind of Medication?:

☐ Clotting *(Mark as appropriate)*
- ☐ Bright in Color
- ☐ Brown / Grainy
- ☐ Stringy
- ☐ Dark in Color
- ☐ Size of Clots : Nickel / Dime / Larger

☐ Bleeding Between Periods ☐ Infertility
☐ Pelvic Inflam. Disease ☐ Ovarian Cysts
☐ STD's ☐ Hot Flashes
☐ Endometriosis ☐ Breast Cysts
☐ Mastitis
☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*
- ☐ Fluid Retention
- ☐ Cravings
- ☐ Fluctuating Emotions
- ☐ Irritability
- ☐ Tenderness in Breasts
- ☐ Depression
- ☐ Fatigue
- ☐ Loose Stool
- ☐ Tender / Weepy

Men Only

☐ Impotence ☐ Weak Erection
☐ Discharge from Penis ☐ Prostate Problems
☐ Testicular Pain or Lump ☐ Infertility
☐ Premature Ejaculation ☐ Low Sex Drive
☐ STD's

Men and Women

Supplements

Name	Purpose	How Long

Diet

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

_____
_____
_____
_____
_____

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!