Michigan Associates of
Acupuncture and
Integrative Medicine

Health History Questionnaire

Name____ Date_____________________

Age__________ Date of Birth___________ Gender___________

Married__ Single__ Separated__ Divorced__ Widowed__ Partnership__

Live with: Spouse__ Partner__ Parents__ Children__ Friends__ Alone__

Please complete these next sections as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

Please list the names of any physicians or medical professionals you work with and what you are seeing them for.

Physician	Condition

What are your most important health problems? List as many as you'd like in order of importance.
1.____
________2.____
________________3.____
________________________4.____
________________________________5.____
____
6.____
____

Hospitalizations and Surgeries

What Hospitalizations, surgeries and tests (MRI, CT scan) have you had?
____
____
____
____
____
____

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Allergies

Are you hypersensitive or allergic to…
Any drugs?______________________________foods__________________________

Current Medications

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking. Please share the condition each medication treats and how long you have been taking the medication.

Medication	Condition	Months/years used

Overall Health

How is your sleep____?
How is your energy____?
Are you every dizzy or lightheaded____?
To you tend to be hot or cold____?
When during the day is your energy best?________________worst?___________

For the Following, Please circle

Y= a condition you have now or **P =** a condition you have had before

Head/Eyes/Neck

Headaches- **Y P**
Migraines- **Y P**
Spots in Eyes-**Y P**
Jaw/TMJ problems- **Y P**
Prior head injury- **Y P**
Ringing in the ears- **Y P**

Respiratory

Frequent colds- **Y P**
Sinus Problems - **Y P**
Shortness of breath- **Y P**
Pneumonia- **Y P**
Phlegm in throat- **Y P**
Asthma - **Y P**
Recurrent Bronchitis- **Y P**
Recurrent Sore Throats- **Y P**
Allergies:____

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Cardiovascular

Heart Disease- **Y P**
High Blood Pressure- **Y P**
Palpitations/Fluttering- **Y P**

Angina- **Y P**
Low Blood Pressure – **Y P**
Chest pain- **Y P**

Gastrointestinal

Bowel movements How often___
is this a change______
Abdominal Pain - **Y P**
Acid Reflux/GERD **– Y P**
Underweight – **Y P**
Normal for Height – **Y P**

Bloating **Y P**
Gas **Y P**
Bloating – **Y P**
Irritable Bowel Syndrome – **Y P**
Overweight – **Y P**
Very Overweight - **Y P**

Genitourinary

Pain on Urination- **Y P**
Frequency at night- **Y P**
Frequent infections- **Y P**

Increased frequency- **Y P**
Kidney Stones- **Y P**
Water retention- **Y P**

Endocrine/Immune

Hypothyroid- **Y P**

Hyperthyroid- **Y P**

Have you been diagnosed with an Autoimmune Disorder? ________________________

Skin

Musculoskeletal

Please tell us about any musculoskeletal issues

____

____

Where do you carry stress in your body?____

____

____

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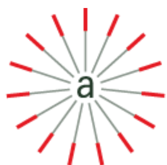

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Sleep

How many hours of sleep do you get on average?______________________

Do you sleep well **Y N** Do you awaken rested? **Y N**

Exercise

Do you exercise? **Y N**

If yes, what kind_________________________How often_________________________

Diet

Do you eat three meals a day **Y N**

Do you drink coffee______

Do you drink cola____

Do you eat out often? **Y N**

Do you eat dairy products _____

Do you eat sugar_____

Diet, Cont.

Tell us a bit about your daily eating habits:

Breakfast____

Lunch-____

Dinner____

Snacks____

Cravings____

Habits

Have you ever been treated for drug dependence? **Y N**

Use recreational drugs? _____

Been treated for alcoholism _____

Smoked previously _____

Use alcoholic beverages ______

Do you use tobacco ______

#packs per day____ # of years___

Lifestyle

Main interests and Hobbies____

How many hours do you watch television? _______________Read? _____________

Take vacations? **Y N** Spend time outside **Y N**

Do you enjoy your work? **Y N**

Spirit

Do you have a religious or spiritual practice? Y N If yes, what?_________________

Are you satisfied with your spiritual life/practice?___________________

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Emotional

Treated for emotional problems- **Y P**
Mood Swings- **Y P**
Often feel angry- **Y P**
Cry Uncontrollably- **Y P**
Have a supportive relationship – **Y P**

Depression- **Y P**
Anxiety or nervousness- **Y P**
Feel Sad often- **Y P**
Irritability- **Y P**
Difficulty concentrating- **Y P**

Any major Traumas?_________________________________
Are you currently seeing a psychologist/therapist? _____________________________________

Anything else?____

The above information is true and accurate

____
Signature Date

Thank you for your time

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