Montgomery Acupuncture Clinic
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Intake Health History Questionnaire Form

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	**Date:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Address:				
Email Address:				
Home Phone:		**Work/Cell:**		
Emergency Contact:		**Emergency Contact Phone:**		
Referring Doctor:		**Date of Last Physical Exam:**		

INSURANCE INFORMATION			
Primary Insurance:		**Policy Holder's ID#:**	
Policy Holder's Name:		**Policy Holder's DOB:**	
Address to Submit Claims:		**Insurance's Phone:**	
		Specialty Co-Pay:	

MEDICAL	
List any medical problems that other doctors have diagnosed	
Surgeries	
Year	Reason
Other Hospitalizations	
Year	Reason
Have you ever had a Blood Transfusion?	☐ Yes ☐ No

List your Prescribed Medication and Over-the-counter drugs, such as Vitamins and Inhalers		
Name the Drug	Strength	Frequency Taken
Allergies/Food		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY								
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL								
Exercise	☐ Sedentary (No exercise)							
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)							
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)							
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)							
Diet	Are you dieting?				☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?				☐	Yes	☐	No
	# Of meals you eat in an average day? _____							
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda				
	# Of cups/cans per day?							
Alcohol	Do you drink alcohol?				☐	Yes	☐	No
	If yes, what kind?							
	How many drinks per week?							
	Are you concerned about the amount you drink?				☐	Yes	☐	No
	Have you considered stopping?				☐	Yes	☐	No
	Have you ever experienced blackouts?				☐	Yes	☐	No
	Are you prone to "binge" drinking?				☐	Yes	☐	No
	Do you drive after drinking?				☐	Yes	☐	No
Tobacco	Do you use tobacco?				☐	Yes	☐	No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day				
	☐ # of years	☐ Or year quit						
Drugs	Do you currently use recreational or street drugs?				☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?				☐	Yes	☐	No
Sex	Are you sexually active?				☐	Yes	☐	No
	If yes, are you trying for a pregnancy?				☐	Yes	☐	No
	If not trying for a pregnancy list contraceptive or barrier method used:							
	Any discomfort with intercourse?				☐	Yes	☐	No
Personal Safety	Do you live alone?				☐	Yes	☐	No
	Do you have frequent falls?				☐	Yes	☐	No
	Do you have vision or hearing loss?				☐	Yes	☐	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No
Have you ever been to a counselor?	☐	Yes	☐	No

OTHER PROBLEMS

ROS	√	**Please check if you CURRENTLY have positive findings of the following:**
Constitutional		☐ Weight Loss ☐ Fevers ☐ Chills ☐ Poor Appetite ☐ Fatigue ☐ Weight Gain ☐ Insomnia ☐ Nights Sweats
Eyes		☐ Blurry Vision ☐ Eye Pain ☐ Eye Discharge ☐ Eye Redness ☐ Decrease in Vision ☐ Dry Eye ☐ Double Vision
ENT		☐ Sore Throat ☐ Hoarseness ☐ Ear Pain ☐ Hearing Loss ☐ Ear Discharge ☐ Nose Bleed ☐ Tinnitus ☐ Sinus Problems
Cardiovascular		☐ Chest Pain ☐ Palpitations ☐ Rapid Heart Rate ☐ Heart Murmur ☐ Poor Circulation ☐ Swelling in the Legs or Feet
Respiratory		☐ Shortness of Breath ☐ Chronic Cough ☐ Coughing up Blood ☐ History of Tuberculosis ☐ Excess Sputum Production
Gastrointestinal		☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the Stool ☐ Frequent Heartburn ☐ Trouble Swallowing
Genitourinary		☐ Increase Urinary Frequency ☐ Blood in Urine ☐ Incontinence ☐ Painful Urination ☐ Urinary Retention ☐ Frequent UTI's
Skin		☐ Rash ☐ Hives ☐ Hair Loss ☐ Skin Scores or Ulcers ☐ Itching ☐ Skin Thickening ☐ Nail Changes ☐ Moles Changes
Musculoskeletal		☐ Joint Pain ☐ Muscle Aches ☐ Frequent Leg Cramps ☐ Muscle Weakness ☐ Bone Pain ☐ Joint Swelling ☐ Back Pain
Psychiatric		☐ Anxiety ☐ Depression ☐ Alcohol or Drug Dependence ☐ Suicidal Thoughts ☐ Panic Attacks ☐ Use of Anti-Depressants
Endocrine		☐ Goiter ☐ Heat Intolerance ☐ Cold Intolerance ☐ Increased Thirst ☐ Change in Skin Pigment ☐ Excess Sweating
Neurological		☐ Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of Balance ☐ Slurred Speech ☐ Stroke
Hem/Lymphatic		☐ Low Blood Count ☐ Easy Bruising ☐ Swollen Lymph Nodes ☐ Transfusions ☐ Prolonged Bleeding ☐ Blood Clots
Allergic/Immun		☐ Allergic Reactions ☐ Hay Fever ☐ Frequent Infections ☐ Hepatitis ☐ HIV Positive ☐ Positive Tuberculin Skin Test (PPD)

WOMEN ONLY

Age at onset of Menstruation: _____				
Date of last Menstruation: _____				
Period every _____ days				
Circle those that apply around time of period; Heavy periods Irregularity Spotting Pain Discharge bloody clots				
Number of Pregnancies _____ Number of Live Births _____ Number of Miscarriages _____ Number of Abortions _____				
Are you Pregnant or Breastfeeding?	☐	Yes	☐	No
Have you had a D&C, hysterectomy or Cesarean?	☐	Yes	☐	No
Any urinary tract, bladder or kidney infections within the last year?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Menopause (Date of onset) _____ Symptoms _____				
Circle those that apply around time of period; Menstrual Tension Pain Bloating Irritability Other symptoms _____				
Endometriosis?	☐	Yes	☐	No
Fibroids?	☐	Yes	☐	No
Experienced any recent Breast tenderness, lumps or nipple discharge?	☐	Yes	☐	No
Date of last pap and rectal exam? _____				

MEN ONLY

Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times _____				
Do you feel pain or burning with urination?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam?				

Additional Information: Use this space to provide any additional informational which may be important to your health care;
Signature of Patient _____ **Date:**_____