MATTHEW BERG
ACUPUNCTURE

Patient Health History

Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Name: _____ Date: _____/_____/_____

Date of Birth: ___/____/___ Age: _____ Gender:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone:_____ Email:_____

Marital status: S M D W

When and where did you last receive health care?:_____

_____

For what reason?:_____

_____

Please identify the health concerns that have brought you to our Clinic in order of importance below: Condition / Past Treatment: _____

_____

_____

_____

_____

_____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):_____

_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:_____

_____

_____

_____

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Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?

_____

Do you have any infectious diseases? Y N If yes, please identify:_____

_____

Height: _____ Weight: Currently: _____ Past Maximum: _____ When? ____

Childhood Illness (please circle any that you have had): Scarlet Fever/Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox Other:_____

Immunizations (please circle any that you have had): Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B Others:_____

_____

Hospitalizations and Surgeries: Reason/Date:_____

_____

_____

_____

X-Rays/CAT Scans/MRI/NMR/Special Studies: Reason/When:_____

_____

Emotional (please circle any that you experience now and underline any that you have experienced in the past): Mood Swings Nervousness Mental Tension Depression Anxiety

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past): Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past): Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing Ear Ringing Ear Aches Headaches Sinus Problems Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory (please circle any that you experience now and underline any that you have experienced in the past): Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy Asthma Tuberculosis Shortness of Breath Other Respiratory Problems:

_____

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Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past): Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past): Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn Belching Gallbladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past): Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past): Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles Menopausal Symptoms Difficulty Conceiving Painful Periods

Menstrual/Birthing History: Age of First Menses: _____ Birth Control Type: _____ # of Abortions: _____ # of Days of Menses: _____ # of Pregnancies: _____ # of Live Births: _____ Length of Cycle: _____ # of Miscarriages: _____

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past): Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past): Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain Low Back Pain Leg Pain Joint Pain (if so, where?):_____

_____

Neurologic (please circle any that you experience now and underline any that you have experienced in the past): Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy Migraines

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Endocrine (please circle any that you experience now and underline any that you have experienced in the past): Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other (please circle any that you experience now and underline any that you have experienced in the past): Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?_____

_____

_____

Lifestyle: Do you typically eat at least three meals per day? Y/ N If no, how many?_____

Exercise_____

Spiritual Practice:_____

How many hours per night do you sleep? _____ Do you wake rested? Y/ N

Level of education completed: High School Bachelors Masters Doctorate Other:_____

Occupation: _____ Employer: _____

Hours/Week: _____ Do you enjoy work? Y/N Why/Why not?:_____

_____

Nicotine/Alcohol/Caffeine Use:_____

_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Have you experienced any major traumas? Y N Please explain:_____

_____

_____

Television habits: _____

Reading habits: _____

Interests and hobbies:_____

_____

_____

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