THE BAREFOOT DOCTOR
COMMUNITY ACUPUNCTURE
AND WELLNESS RESOURCE CENTER

Health History Questionnaire

Name _____ Date ____/_____/_____

Please complete this questionnaire as thoroughly as possible.

What condition(s) are your primary concerns in coming for treatment?

1)

2)

3)

Family History:
Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

	Father	Mother	Brothers	sisters	Child	spouse
Health (G=good; P=poor)						
Age, if living						
If deceased, age at death						
Cause of death						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hay fever, hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

Height _____ Current Weight _____lb. Maximum Weight _____lb. When? _____

Childhood Illnesses:

Scarlet Fever	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Diphtheria	Yes	No
Measles	Yes	No
Pneumatic fever	Yes	No
German Measles	Yes	No

Immunizations:

Measles/Mumps/Rubella	Yes	No
Tetanus	Yes	No
When? _____		
Pertussis	Yes	No
Polio	Yes	No
Diphtheria	Yes	No
Other	Yes	No

ALLERGIES:
Are you hypersensitive or allergic to:
Any Drugs? ____ Yes ____ No Please List:

_____

_____

Any Foods? ____ Yes ____ No Please List:

_____

_____

MEDICATIONS:
Please list any prescription medications, over the counter medications, vitamins, or other supplements you are currently taking:

_____

_____

SYMPTOM PROFILE:
For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you've had in the past, noting the date in the space provided.

SKIN:

Currently Have?	YES	PAST	When?
Acne, Boils	___	___	_____
Acute Hair Loss	___	___	_____
Color Change	___	___	_____
Eczema, Hives	___	___	_____
Itching	___	___	_____
Nail Fungus	___	___	_____
Psoriasis	___	___	_____
Rash	___	___	_____
Other_____	___	___	_____

RESPIRATORY:

Currently Have?	YES	PAST	When?
Bronchitis	___	___	_____
Chronic Asthma	___	___	_____
Chronic Cough	___	___	_____
Emphysema	___	___	_____
Frequent Colds	___	___	_____
Pain in Breathing	___	___	_____
Pleurisy	___	___	_____
Pneumonia	___	___	_____
Shortness of Breath	___	___	_____
Sinus Congestion	___	___	_____
Spitting Up Blood	___	___	_____
Temporary Cough	___	___	_____
Tuberculosis	___	___	_____

MENTAL/ EMOTIONAL

Currently have?	YES	PAST	When?
Anxiety	___	___	_____
Depression	___	___	_____
Considered or Attempted Suicide	___	___	_____
Irritability	___	___	_____
Mood Swings	___	___	_____
Other_____	___	___	_____

HEAD/ EARS/ EYES/ NOSE/ MOUTH:

Currently Have?	YES	PAST	When?
Head:			
Headaches	___	___	_____
Migraines	___	___	_____
Head Injury	___	___	_____
Hay Fever	___	___	_____
Ears:			
Earaches	___	___	_____
Ringing in Ears	___	___	_____
Impaired Hearing	___	___	_____
Dizziness	___	___	_____
Eyes:			
Cataracts	___	___	_____
Color Blindness	___	___	_____
Contacts or Glasses	___	___	_____
Double Vision	___	___	_____
Eye Pain or Strain	___	___	_____
Glaucoma	___	___	_____
Impaired Vision	___	___	_____
Tearing or Dryness	___	___	_____
Spots in Front of Eyes	___	___	_____
Nose:			
Nose Bleeds	___	___	_____
Loss of Smell	___	___	_____
Mouth:			
Bleeding Gums	___	___	_____
Dental Cavities	___	___	_____
Dry Mouth	___	___	_____
Oral Sores	___	___	_____
Oral Thrush	___	___	_____
Teeth Grinding	___	___	_____
Jaw Problems, TMJ	___	___	_____

THROAT:

	YES	PAST	When?
Goiter	___	___	_____
Hoarseness	___	___	_____
Swollen Glands	___	___	_____

Trouble Swallowing	___	___	_____
Neck Pain/ Stiffness	___	___	_____
Frequent Sore Throat	___	___	_____
Other_____			_____

DIGESTION:

Currently Have?	YES	PAST	When?
Nausea	___	___	_____
Vomiting	___	___	_____
Loss of Appetite	___	___	_____
Ulcer	___	___	_____
Heartburn	___	___	_____
Gas or Bloating	___	___	_____
Internal Cramping	___	___	_____
Constipation	___	___	_____
Diarrhea	___	___	_____
Loose Stool	___	___	_____
Hemorrhoids	___	___	_____
Bowel Movement Frequency? _____x per day			
Is this a change?	___	___	_____
Other_____			_____

CARDIOVASCULAR:

Currently Have?	YES	PAST	When?
Heart Disease	___	___	_____
Endocarditis	___	___	_____
Chest Pain	___	___	_____
Heart Murmur	___	___	_____
Palpitations or Fluttering	___	___	_____
High Blood Pressure	___	___	_____
Low Blood Pressure	___	___	_____
Phlebitis	___	___	_____
Blood Clots	___	___	_____
Ankle Swelling	___	___	_____
Fainting	___	___	_____
Other_____	___	___	_____

URINARY TRACT:

Currently Have?	YES	PAST	When?
Frequent Infection	___	___	_____
Night Urination	___	___	_____
Inability to Hold Urine	___	___	
Burning or Pain During Urination	___	___	_____
Increased Frequency	___	___	_____
Kidney Stones	___	___	_____
Other_____	___	___	_____

MUSKULOSKELETAL:

Currently Have?	YES	PAST	When?
Weakness	___	___	_____
Muscle Spasms or Cramps	___	___	_____
Joint Pain, Swelling, or Stiffness			
Sciatica	___	___	_____
Fibromyalgia	___	___	_____
Broken Bones	___	___	_____
Any Other Pain	___	___	_____
Location: _____			
Other _____		___	_____

MISCELLANIOUS:

Currently Have?	YES	PAST	When?
Easy Bleeding or Bruising	___	___	_____
Varicose Veins	___	___	_____
Anemia	___	___	_____
Slow Wound Healing	___	___	_____
Chronic Infections	___	___	_____
Day Sweats	___	___	_____
Night Sweats	___	___	_____
Cold Hands or Feet	___	___	_____
Heat or Cold Intolerance	___	___	_____
Fatigue	___	___	_____
Chronic Fatigue Syndrome			
Hypoglycemia	___	___	_____
Hyperthyroid	___	___	_____
Excessive Thirst	___	___	_____
Excessive Hunger	___	___	_____
Diabetes	___	___	_____
Gallbladder Disease	___	___	_____
Liver Disease	___	___	_____
Jaundice	___	___	_____
Hepatitis	___	___	_____
Type? _____			
Other_____			_____

LIFESTYLE:

Do You….	YES	NO
Exercise?	___	___
What Kind? _____		
How Often? _____		

Do You….	YES	NO
Take Vacations?	____	____
Sleep Well?	____	____
Awaken Rested?	____	____
Average 6-8 Hours Sleep?	____	____
Spend Time Outside?	____	____

What time of day is your energy at its best?

_____

Tobacco, Food and Drink Habits:

Do you…	YES	NO
Use Tobacco?	____	____
How Much _____		
Smoked Previously?	____	____
How Long? _____		
How many packs per day? _____		
Ever been treated for drug dependence?	____	____
Drink Alcohol?	____	____
How much? _____		
Drink Caffeinated Beverages?	____	____
How often? _____		
Eat out often?	____	____
How many times per week? _____		
How many meals do you eat per day? _____		
Go on diets often?	____	____

Typical Food Intake:

Breakfast _____

Lunch _____

Dinner _____

Snacks_____

Any History of Psychological, Physical or Sexual Abuse? YES NO

Is there anything you feel is important for us to know regarding this? _____

FOR MEN ONLY:

Do you now, or have you ever had…?		When?
Testicular Masses	___ Yes	_____
Testicular Pain	___ Yes	_____
Prostate Disease	___ Yes	_____
Impotence	___ Yes	_____
Premature Ejaculation	___ Yes	_____
Hernias	___ Yes	_____
Condyloma	___ Yes	_____
Syphilis	___ Yes	_____
Genital, Oral or Rectal Herpes	___ Yes	_____
Gonorrhea	___ Yes	_____
Other _____	___ Yes	_____

FOR WOMEN ONLY:

Do you now, or have you ever had…?		When?
Breast Lumps	___ Yes	_____
Nipple Discharge	___ Yes	_____
Breast Pain or Tenderness	___ Yes	_____
Abnormal PAP Smear	___ Yes	_____
Cervical Dysplasia	___ Yes	_____
Vaginal Discharge	___ Yes	_____
Gonorrhea	___ Yes	_____
Syphilis	___ Yes	_____
Genital, Oral or Rectal Herpes	___ Yes	_____
Condyloma	___ Yes	_____
Fibroids	___ Yes	_____
Ovarian Cysts	___ Yes	_____
Sexual Difficulties	___ Yes	_____
Are you sexually active?	___ Yes	_____
Are you on birth control?	___ Yes	_____
Number of Pregnancies		_____
Number of Live Births		_____
Number of Miscarriages		_____
Number of Abortions		_____
Age at first menses		_____
Length of cycle in days		_____
Duration of period in days		_____
PMS Symptoms	___ Yes	_____
Painful Menses	___ Yes	_____
Clotting during menses	___ Yes	_____
Bleeding between periods	___ Yes	_____
Menopausal symptoms	___ Yes	_____
Other _____	___ Yes	_____