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Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention which is not asked on this form, please note it in the *Comments* section. Thank You.

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Height: _____ Weight: _____ Sex: _____
_____ Social Security #: _____
_____ Employer: _____
Phone: (H) _____ (W) _____ Occupation: _____
email: _____ Marital Status: _____ Spouse's Name: _____
Physician: _____ Referred to this office by: _____
In Emergency, Notify: _____ Relationship: _____ Phone: _____

Main problem you would like help with: _____

When did the problem begin (be specific): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____

Have you been given a diagnosis for the problem? If so, what? _____

What kind of treatments have you tried? _____

Other concurrent therapies: _____

Past Medical History – please note dates:

Cancer: _____	HIV/AIDS: _____	Thyroid Disease: _____
Diabetes: _____	High Blood Pressure: _____	Rheumatic Fever: _____
Hepatitis: _____	Heart Disease: _____	Venereal Disease: _____

Surgeries (types & dates): _____

Significant Traumas: _____

Significant Dental Work: _____

Other: _____

Allergies (drugs, chemicals, foods, etc.) _____

Occupational Stress (chemical, physical, psychological) _____

Birth History (prolonged labor, forceps, premature, etc.) _____

Family Medical History

- Cancer
- Heart Disease
- Asthma
- Diabetes
- Stroke
- Allergies
- High Blood Pressure
- Seizures
- Other _____

Medications

What medications and/or supplements are you currently taking? _____

Have you had any courses of antibiotics recently? Many A few 1 or 2 None

Habits

Do you have a regular exercise program? Please describe: _____

Are you or have you been on a restricted diet? What kind and why? _____

Please indicate usage per day or per week:

- | | |
|----------------------------|-----------------------------|
| Cigarettes _____ per _____ | Tea _____ per _____ |
| Alcohol _____ per _____ | Soft Drinks _____ per _____ |
| Drugs _____ per _____ | Sugar _____ per _____ |
| Coffee _____ per _____ | Other _____ per _____ |

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

- Recurrent Infections
- Night Sweats
- Sweat easily
- Bleed or bruise easily
- Strong thirst (prefer hot or cold?)
- Thirst with no desire to drink
- Fatigue
- Sudden energy drops
Time of day _____
- Poor Sleep
- Tremors
- Poor Balance
- Edema
- Underweight
- Overweight

- Oozing
- Pimples
- Dry skin / scalp
- Recent moles
- Changes in hair/skin
- Other _____

Head/Eyes/Ears/Nose/Throat

- Headaches
Where _____
When _____
- Migraines
- Dizziness
- Discharge from ear
- Poor hearing
- Ringing in ears

- Eye Pain
- Excessive Tearing
- Squint
- Glasses
- Sore eyes
- Facial Pain
- Nose bleeds
- Nasal discharge
- Blocked nose
- Snoring
- Grinding teeth
- Teeth problems
- Recurrent sore throat
- Hoarseness
- Tonsillitis
- Swollen glands

Skin

- Rashes
- Itching
- Eczema

Cardiovascular

- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Chest discomfort/pain
- Heart Palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood Clots
- Spider veins
- Fainting
- Other _____

Respiratory

- Difficulty breathing
- Pain with breathing
- Shallow breathing
- Shortness of breath
- Production of phlegm
color _____
- Recurrent cough
- Bronchitis
- Pneumonia
- Asthma/Wheezing
- Status asthmaticus
- Other _____

Digestion

- Bad breath
- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Belching
- Abdominal pain or cramps
- Weight gain
- Weight loss
- Loose stools / Diarrhea
- Strong smelling stools
- Bloody stools
- Pale stools
- Green stools
- Black stools
- Constipation
(not daily, or difficult)
- Pain with passing stools
- Gas
- Rectal pain

- Blurry vision
- Night blindness
- Color blindness
- Spots in front of eyes

Genito-urinary

- Pain on urination
- Urgency with urination
- Frequent urination
- Blood in urine
- Decrease in urinary flow
- Unable to hold urine
- Incontinence at night
- Dribbling urination
- Kidney stones
- Prostate problems
- Impotency
- Changes in sexual drive
- Rashes
- Do you wake at night to urinate?
How many times? _____
- Other _____

Gynecological

- # of pregnancies _____
- # births _____
- # premature births _____
- # abortions _____
- Age of 1st menses _____
- # days between menses _____
- Duration of menses _____
- 1st day of last menses _____
- Age of menopause _____
- Date of last PAP _____

- PMS
- Irregular periods
- Painful periods
- Light periods
- Heavy periods
- Clots
- Fibroids
- Endometriosis
- Infertility
- Vaginal discharge
- Vaginal sores
- Postcoital bleeding
- Breast lumps
- Nipple discharge
- Other _____

- Do you practice birth control?
 yes no
what type and for how long?

- Sores on lips/mouth
- Other _____

Musculoskeletal

- Neck ache/pain
- Back ache/pain
- Knee ache/pain
- Shoulder pain
- Elbow/Forearm pain
- Hand/Wrist pain
- Foot/Ankle pain
- Joint/Bone problems
- Torn tissues
- Prostheses
- Muscle pain/weakness
- Hernia
- Other _____

Neurological

- Seizures
- Nerve damage
- Paralysis
- Stroke
- Sleep disorder
- Concussion
- Vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty in concentrating
- Other _____

Behavioral

- Vacant
- Moody
- Easily susceptible to stress
- Aggressive/Bad temper
- Lose control of emotions
- Anxiety
- Panic Attacks
- Depression
- Fear
- Substance abuse
- Other _____

- Have you ever been treated for emotional problems?
 yes no

- Have you ever considered or attempted suicide?
 yes no

- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Other _____

Are you pregnant now?
 yes no

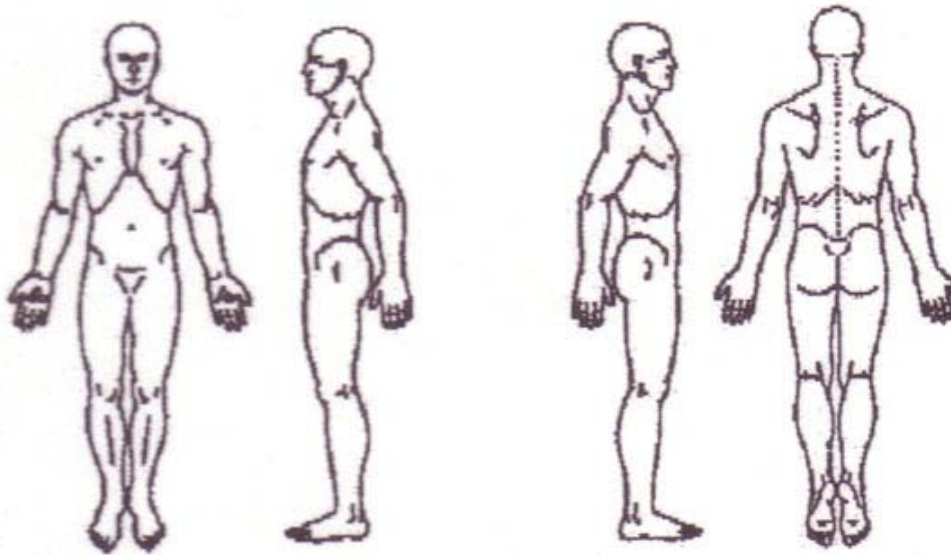
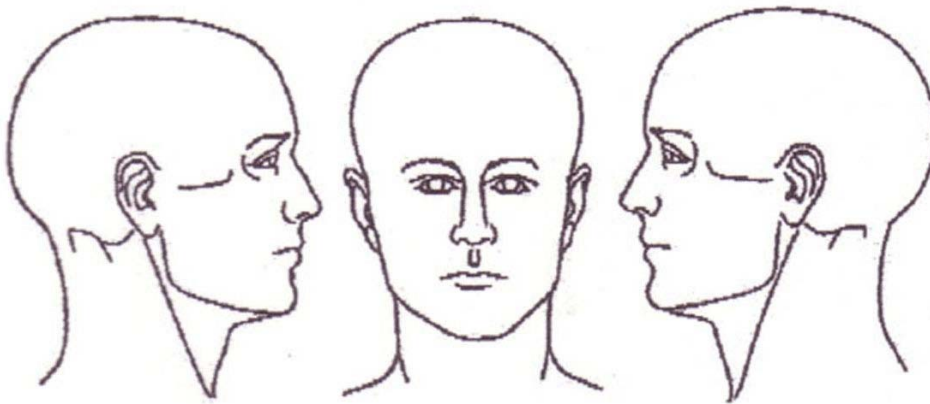
Please note the severity of your problem right now:

No Problem Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No Problem Worst Imaginable

Please indicate areas of pain or distress:



Comments: _____

