Riverpath Clinic
HEALTH HISTORY QUESTIONNAIRE

Welcome to Riverpath Clinic. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. If you need more space, please use the back of the form. All information given is confidential. Thank you.

Personal Information

Today's Date ____________________

Name ______________________________ Home phone ____________________

Address ______________________________ Other phone ____________________

City ____________________ State ____________________ Zip code ____________________

E-mail address:______________________________ *May we contact you by e-mail?** ❑ Yes ❑ No

How will you pay for your treatments: ❑ Cash or check ❑ Credit Card ❑ Insurance ❑ Medical Savings Account

Date of birth ____________________ Height ____________________ Weight ____________________

Occupation______________________________

Satisfaction with work:______________________________

Spouse/partner's name: ____________________ No. of children: __________ Ages: __________

Emergency contact name:____________________Phone: ____________________

Current health care professional:______________________________

Have you ever experienced Asian medicine before? ❑Acupuncture ❑Herbal medicine ❑Shiatsu/Asian bodywork

From whom: ______________________________

*How did you hear about Riverpath Clinic?*______________________________

** Your e-mail address will not be shared outside of this clinic*

Current Condition

Primary reason for today's visit:

____

How long have you had this condition: ______________________________

Is it getting worse? ❑ Yes ❑ No *Does it interfere with:* ❑ Sleep ❑ Work ❑ Other____________________

What seemed to be the initial cause?

____

What makes it worse? ______________________________

*What makes it better?*______________________________

Have you ever been given a diagnosis for this condition? ❑ Yes ❑ No *If so, what and by whom?*

____

What treatments have you tried?

____

What medications (prescription or OTC drugs, herbs, vitamins, etc.) are you currently taking?

Date began	Drug/Vitamin/Supplement	Dose

Secondary complaints

Please list any other health conditions or concerns you have:

Past medical history

Please check all that apply and give dates:

- ❑ Cancer ______________________
- ❑ Diabetes ______________________
- ❑ Hepatitis ______________________
- ❑ High/Low Blood Pressure_________
  Rate ______________________
- ❑ Asthma ______________________
- ❑ Heart disease ________________
- ❑ Rheumatic Fever _______________
- ❑ Thyroid disease ________________
- ❑ Seizures ______________________
- ❑ Pneumonia _________________
- ❑ HIV/AIDS ___________________
- ❑ Drug/alcohol addiction__________
- ❑ Frequent colds/flus ____________
- ❑ Bronchitis __________________
- ❑ Allergies (describe) ____
- ❑ Other (describe) ____

Surgeries, serious illnesses, physical traumas (accidents, injuries, abuse, etc.)**:**

Date	Describe

Emotional trauma (divorce, change of residence or employment, death of loved one, emotional abuse, etc.)**:**

Date	Describe

Please list any major diseases, illnesses, deaths and their causes of your immediate family:

Date	Describe

Lifestyle

Please check all that apply and describe how much and how often:

- ❑ Tobacco use ______________________________
- ❑ Alcohol ______________________________
- ❑ Coffee ______________________________
- ❑ Tea ______________________________
- ❑ Soft drinks ______________________________
- ❑ Laxatives ______________________________
- ❑ Aspirin or other OTC pain med___________________
- ❑ Therapy or counseling___________________
- ❑ Exercise ______________________________
- ❑ Meditate ______________________________
- ❑ Stress ______________________________
- ❑ Occupational hazards_________________________

General Health

Please check all that apply

Appetite ❑ Low ❑ Normal ❑ High
Diet: ❑ Standard ❑ No red meat ❑ Lacto-vegetarian ❑ Vegetarian ❑ Vegan ❑Other________________
Taste cravings: ❑ Sweet ❑ Salty ❑ Spicy ❑ Bitter ❑ Sour
Tend to feel ❑ Cold ❑ Hot ❑ Normal ❑ All over ❑ Extremities
Predominant emotions: ❑ Fear ❑ Joy ❑ Anger ❑ Grief/Sadness ❑ Worry/Guilt/Obsessing
❑ Other: ____

❑ Heavy sleep	❑ Fevers	❑ Bleed/bruise easily	❑ Lymphatic swelling
❑ Difficulty getting to sleep	❑ Chills	❑ Weight loss	❑ Varicose veins
❑ Difficulty staying asleep	❑ Night sweats	❑ Weight gain	❑ Prefer cold drinks
❑ Dream-disturbed sleep	❑ Sweat easily	❑ Peculiar tastes/smells	❑ Prefer hot drinks
❑ Fatigue	❑ Tremors	❑ Edema	❑ Sudden energy drop

Musculoskeletal

❑ Neck pain	❑ Hip pain	❑ Hand/wrist pains	❑ Swollen joints
❑ Shoulder pains	❑ Knee pain	❑ General muscle pain	❑ Numbness
❑ Back pain	❑ Foot/ankle pains	❑ Muscle weakness	❑ Tremors

Cardiovascular

❑ Heart palpitations	❑ Irregular heartbeat	❑ Blood clots	❑ Cold hands/feet
❑ Chest pain	❑ Fainting	❑ Swelling of hands/feet	❑ Hot hands/feet

Respiratory

❑ Difficulty breathing	❑ Tight chest	❑ Cough	❑ Pneumonia
❑ Shortness of breath	❑ Weak voice	❑ Congestion	❑ Frequent infections

Gastrointestinal

❑ Nausea	❑ Belching	❑ Hemorrhoids	❑ Disinterest in eating
❑ Vomiting	❑ Hiccups	❑ Stomach acid	❑ Abdominal pain or cramps
❑ Diarrhea Constipation	❑ Indigestion	❑ Low body weight	❑ Abdominal bloating
❑ Gas	❑ Bad breath	❑ Frequent desire to eat	❑ Gurgling in stomach

Neurological, Psychological

❑ Seizures	❑ Lack of coordination	❑ Anxiety	❑ Indecisive
❑ Dizziness	❑ Poor memory	❑ Irritable	❑ Fearful
❑ Loss of balance	❑ Concussion	❑ Have anger	❑ Easily stressed
❑ Areas of numbness	❑ Depression	❑ Lose temper easily	❑ Thoughts of suicide

Head, Eyes, Ears, Nose, Throat

❑ Wear glasses	❑ Eye strain	❑ Ringing in ears	❑ Facial pain
❑ Night blindness	❑ Eye pain	❑ Poor hearing	❑ Sores on lips/tongue
❑ Color blindness	❑ Dry eyes	❑ Sinus problems	❑ Teeth problems
❑ Cataracts	❑ Migraines	❑ Nose bleeds	❑ Jaw clicks
❑ Spots in front of eyes	❑ Headaches	❑ Recurrent sore throats	❑ Dry mouth
❑ Blurry vision	❑ Earaches	❑ Grinding teeth	❑ Excessive saliva

Skin and Hair

❑ Dry skin/hair	❑ Oily skin/hair	❑ Skin rash	❑ Psoriasis
❑ Dandruff	❑ Acne/pimples	❑ Itching	❑ Recent moles
❑ Loss of hair	❑ Open sores on skin	❑ Eczema	❑ Cysts/tumors

Genito-Urinary

❑ Frequent urination	❑ Painful urination	❑ Unable to hold urine	❑ STD _____________
❑ Wake up to urinate	❑ Decrease in urination	❑ Blood in urine	❑ Reduced sex drive

Women

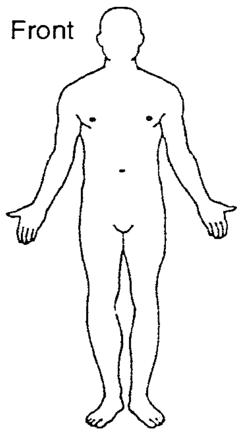
❑ Age of first menses_____	❑ Blood clots	❑ Peri-menopausal	❑ Miscarriages #_____
❑ Heavy menses_____days	❑ Ovarian cyst	❑ Menopause at age______	❑ Abortions #_____
❑ Light menses ______days	❑ Yeast infection	❑ Pregnancies #_________	❑ Currently pregnant
❑ Irregular menses	❑ Endometriosis	❑ Live births #___________	❑ How many mos?_______
❑ Painful menses	❑ Infertility	❑ Premature births #______	
❑ PMS _______days	❑ Hysterectomy at age____	❑ C-section deliveries#____	

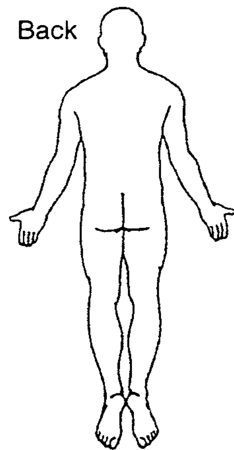
Men

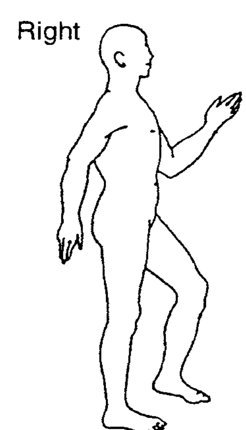
❑ Erectile dysfunction	❑ Premature ejaculation	❑ Painful/swollen testicles	❑ Painful or difficult ejaculation
❑ Prostatitis	❑ Nocturnal emissions	❑ Performance anxiety	

Areas of Pain

Please mark all painful areas







Additional Comments

Please provide any additional important information about which may not have been covered in this questionnaire: