Lutea Acupuncture & Herbal Medicine, LLC
Lara Diaz, L.Ac., Dipl.O.M. www.luteaherbs.com 828-582-5403
372 Depot St. Suite 20, Asheville, NC 28801

Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. Some questions may seem unrelated to your main complaint—this is because acupuncture looks at the whole person. How your different systems are working and interacting may help in the diagnosis and aid in treatment of the main problem.

Name:_____ **Age**_____ **Birth Date**_____ **Sex: M / F**

Address_____ **City**_____ **Zip Code**_____

Evening Phone_____ **Day Phone**_____ **Email**_____

In Emergency, Notify_____ **Phone**_____

Referred by_____ **Family Physician**_____

Current Health Concerns

Please list your health concerns. Begin with the most important to address today.

Classify your health concern as 1= Minor; 2 = Moderate; 3 = Fairly severe and getting worse; 4 = Serious

	Classified As	Date of Onset
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

To what extent do these problems interfere with or impact your daily activities (work, sleep, play)?

What type of service(s) do you desire?

_____ 1. Relief of symptoms/ pain control

_____ 2. Eradication of tendencies causing your condition

_____ 3. Holistically and balanced health, including emotions – elimination of root/cause of problem

_____ 4. Maintenance-care – regular balancing and ”tune-ups” to keep in optimum health; proactive

Please list some of the most significant events in your life, beginning with the most recent, (such as marriage/divorce, birth of child, career changes, personal or professional recognition, periods of grief, accidents)

1. _____
2. _____
3. _____
4. _____

General Information

Yes	No		Yes	No	
		Have you had acupuncture before?			Do you have hepatitis, cancer or HIV?
		Do you bruise easily?			Have you recently traveled outside US?
		Do you bleed for a long time from a cut?			Women: Are you pregnant?
		Do you have a tendency to faint?			Women: Are you perimenopausal?
		Are you nervous about needles?			Women: Have you reached menopause?
		Are you generally very tired?			Have you ever been treated for emotional problems
		Do you have high blood pressure?			Have you ever considered or attempted suicide?
		Do you have a pacemaker?			

Personal Health Habits

Yes **No**

Smoker Smoked for _____ years. Smoke _____ pack(s) per day currently. If stopped, year: _____

_____ Alcohol Type_____ Frequency

_____ Recreational Drugs Type _____ Frequency

_____ Coffee Cups per day _____ Water per day: _____

Regular Exercise

If so, describe type and frequency_____

Height _____ Current Weight _____ lbs. Weight 1 year ago: _____ lbs.

Stress: What do you currently find most stressful?

_____

_____

Daily Diet: Please describe an average daily diet:

Morning_____

_____

Lunch

_____

Evening_____
Snacks
_____

Sleep: How much do you generally get at night? _____ hours.

Do you dream, if so how often? _____ Do you fall a sleep easily? **Yes/ No**

Do you wake up often? **Yes / No** A specific time? _____

Energy: Are you happy with your level of energy? **Yes / No** My energy is highest at what time of day? _____ It is lowest at what time? _____ On a scale of 1-10, (10 very high) what is your energy? _____

Hospitalization/ Accidents

Please list any hospitalizations, surgery, serious injuries, and recent dental work with a short description and date.

_____

_____

_____

Current & Former Conditions

Do You Have Any Of The Following?

√ **Check Mark** any of the following that you are experiencing **now** or have **experienced in the past 3 months.**

General Symptoms	**Ears, Eyes, Nose & Throat**	**Cardiovascular**
Headache or Migraines	Facial or Eye pain	High blood pressure
Feels warm most of the time	Failing vision/ eye strain	Low blood pressure
Abnormal sweating	Eye inflammation	Irregular heartbeat
Night sweats or wake from warmness	Poor vision/ blurred vision	Palpitations
Feels cold most of the time	Spots floating in eyes	Chest pain/ pressure
Fatigue	Dry eyes	Varicose veins
Fainting	Ear discharges	Swelling in hands/ feet
Dizziness/ tremors	Earaches	**Neurological**
Convulsions	Poor hearing	Spasms
Decreased motivation	Ringing in the ears	Numbness/ tingling
Difficulty focusing	TMJ	Paralysis
Poor memory	Tooth or gum problems	**Female**
Decreased libido	Frequent cold sores	Pregnancies _____
Respiratory	Teeth grinding	Births
Chronic Cough	Nose bleeds	Premature/ Miscarriages _____
Coughing with blood	Nasal congestion	Stillborn/ Abortions
Difficulty breathing	Hay fever/ allergies	First menses _____
Shortness of breath	Asthma	Last pap _____
Spitting up phlegm	Loss of taste	Date of last menses _____
Frequent colds/ flu	Recurrent sore throat	Duration of menses _____
Gastrointestinal	**Dermatology**	Days between menses _____

Nausea/ Vomiting	Acne	Painful menstrual periods
Poor appetite	Rashes/ Hives	Pre-menstrual emotions
Food cravings	Itchy skin	Excessive flow
Indigestion	Dry skin	Hot flashes/ night sweats
Abdominal pain	Bruise easily	Cramps or backache
Flatulence	Clammy skin	Breast soreness/ lumps
Bloating	**Genitourinary**	Vaginal discharge
Loose stools/ diarrhea	Bladder problems/ UTIs	Vaginal sores/ History of STD's
Male Issues	Pain/Burning with urination	**Emotions**
Last prostate exam _____	Blood in urine	Irritability/ anger issues
Impotence/ Fertility issues	Urgency to urinate	Depression
Penile Sores/ discharge	Frequent urination	Anxiety
Musculoskeletal	Difficulty urinating	Mood Swings
Joint Pain Stiffness	Incontinence	Recent loss
Muscle weakness	Scanty dark urine	Fear
Bone problems/ Arthritis	Abundant pale urination	Ongoing worry

Medications/ Vitamins

Please list all your medications (including sleeping pills, birth control) and non-prescription drugs (such as Aspirin, antacids, laxatives, antihistamines) that you take on a regular basis.

_____
_____
_____
_____
_____
_____

Please list all vitamins or supplements you are taking on a regular basis and their dosage.

_____
_____
_____
_____
_____

Thank you for your time spent with this form. I appreciate your time spent, but also your willingness to share things that maybe are not normally asked.