Acupuncture at Energetic Health Center of Boise

1003 N Orchard St, Boise, ID 83706
(208) 376-3113

Confidential Health History Questionnaire Date:___________________________

We look forward to helping you achieve your health goals. Please help us learn more about you so that we may provide you with the most effective care. On this questionnaire, you will find many in-depth questions; each answer provides important information that allows us to optimize your health care results. Thank you for your thorough responses.

Last Name	First Name	Middle Initial	Pace Maker or Electrical Devices?

Street Address	City	State	Zip

Home Phone	Cell Phone	Permission to text your appointment reminders? Yes No	Age	Sex	Date of Birth

Marital Status	Employer & Occupation	Emergency Contact: Name & Phone

Height	Weight	Blood Pressure	Date of BP Reading	Blood Type

E-mail Address (for newsletters & appointment reminders)	How did you hear about us?

Are you currently under Doctor's care?	MD's Name	MD's Phone

List your reasons for today's visit, in order of importance.

What treatments have you tried or are you currently doing for these conditions?

Check if you have a FAMILY HISTORY of any of these:

☐ Allergies	☐ Diabetes	☐ Kidney disease
☐ Arthritis	☐ Epilepsy / Seizures	☐ Mental illness
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleeding disorders	☐ Heart disease	☐ Thyroid disease
☐ Cancer	☐ High blood pressure	☐ Other inheritable disease

Please identify current symptoms by marking the box under the "Now" column.
Mark the "Past" column only if a past condition was particularly severe or significant.

Past Now

☐ ☐ Abdominal / stomach pain
☐ ☐ Abnormal appetite
☐ ☐ Nausea / vomiting
☐ ☐ Belching
☐ ☐ Heartburn / reflux
☐ ☐ Gas
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Black stool
☐ ☐ Blood in stool
☐ ☐ Mucous in stool
☐ ☐ Undigested food in stool
☐ ☐ Rectal pain / hemorrhoids
☐ ☐ Regular laxative use
☐ ☐ Unusually thirsty
☐ ☐ Overweight
☐ ☐ Weight changes

☐ ☐ Bleeding / bruising easily
☐ ☐ Bleeding gums
☐ ☐ Poor circulation
☐ ☐ Dizzy spells or fainting
☐ ☐ Chest pain / pressure
☐ ☐ Irregular heart beat
☐ ☐ Palpitations / chest fluttering
☐ ☐ Pounding heart beat
☐ ☐ Racing heart beat

☐ ☐ Chronic cough
☐ ☐ Coughing blood
☐ ☐ Frequent chest colds
☐ ☐ Shortness of breath
☐ ☐ Tightness of chest
☐ ☐ Wheezing
☐ ☐ Coughing up Phlegm
Color of Phlegm______________

☐ ☐ Chronic or recurrent infection
☐ ☐ Fatigue or tiredness
☐ ☐ Sudden energy drop at _____
☐ ☐ Frequent antibiotic use

Past Now

☐ ☐ Chills
☐ ☐ Fever
☐ ☐ Excessive sweating
☐ ☐ Lack of perspiration
☐ ☐ Hot flashes
☐ ☐ Night sweats
☐ ☐ Cold Hands/Feet/Nose
☐ ☐ Tendency to be too hot
☐ ☐ Tendency to be too cold

☐ ☐ Dry eyes
☐ ☐ Eye pain
☐ ☐ Itchy eyes
☐ ☐ Tearing eyes
☐ ☐ Poor vision
☐ ☐ Night or color blindness
☐ ☐ Earaches
☐ ☐ Ringing or sounds in ears
☐ ☐ Hearing problems
☐ ☐ Sinus problems
☐ ☐ Sneezing
☐ ☐ Snoring
☐ ☐ Nose bleeds
☐ ☐ Dry mouth or throat
☐ ☐ Sore throat
☐ ☐ Swollen glands
☐ ☐ Frequent hoarseness
☐ ☐ Mouth or lip sores
☐ ☐ Many cavities or root canals
☐ ☐ Unusual taste in mouth
☐ ☐ Teeth grinding or clenching
☐ ☐ Jaw Problems or TMJ
☐ ☐ Facial pain
☐ ☐ Headaches

☐ ☐ Blood in urine
☐ ☐ Burning or painful urination
☐ ☐ Difficult urination / retention
☐ ☐ Frequent or urgent urination
☐ ☐ Frequent urination at night
☐ ☐ Loss of bladder control

Past Now

☐ ☐ Anger
☐ ☐ Anxiety
☐ ☐ Depression
☐ ☐ Fear
☐ ☐ Frustration
☐ ☐ Grief or sadness
☐ ☐ Irritability
☐ ☐ Mood swings
☐ ☐ Obsession
☐ ☐ Panic Attacks
☐ ☐ Stress
☐ ☐ Worry

☐ ☐ Victim of Child Abuse
☐ ☐ Victim of Domestic Abuse
☐ ☐ Victim of Sexual Abuse
☐ ☐ War Veteran

☐ ☐ Acne pimples
☐ ☐ Dry skin / Oily Skin
☐ ☐ Itching or burning skin
☐ ☐ Skin rash or sores
☐ ☐ Tendency to get hives
☐ ☐ Scalp itching or flaking
☐ ☐ Early graying of hair
☐ ☐ Loss of hair
☐ ☐ Nail fungus
☐ ☐ Weak / brittle nails

☐ ☐ Numbness or tingling
☐ ☐ Poor concentration
☐ ☐ Poor memory
☐ ☐ Seizures or convulsions
☐ ☐ Shaking or trembling
☐ ☐ Stuttering or stammering

☐ ☐ Difficulty falling asleep
☐ ☐ Waking up frequently
☐ ☐ Wake up still tired
☐ ☐ Many dreams
☐ ☐ Nightmares

LIFESTYLE & DIET

☐ Tobacco ☐ E-Cigarettes ☐ Marijuana ☐ Coffee (amt): ____________ ☐ Tea (amt):______________ ☐ Soft Drinks (amt):__________ ☐ Energy Drinks (amt) ________ ☐ Alcohol (amt): ___________ ☐ Water (amt): _____________	☐ Recreational Drugs ☐ High Stress ☐ Occupational Hazards ☐ Artificial Sweeteners ☐ Fast Food ☐ Vegetarian/ Vegan ☐ High Protein ☐ Gluten-free ☐ Low Fat ☐ Crave Sugar ☐ Crave Salt	Exercise: (describe) Herbs/Vitamins/Supplements: (list)

FOR MEN

Past Now ☐ ☐ Genital pain, swelling or itching ☐ ☐ Abnormal sex drive [ ] high [ ] low ☐ ☐ Erectile dysfunction	**Past Now** ☐ ☐ Low sperm count / motility / morphology ☐ ☐ Penile discharge ☐ ☐ Prostate problem (PSA reading:__________)

FOR WOMEN

Past Now ☐ ☐ Abnormal PAP smear ☐ ☐ Abnormal sex drive ☐ ☐ Abortion history ☐ ☐ Bleeding between periods ☐ ☐ Breast lumps / tenderness ☐ ☐ Clots in menstrual blood ☐ ☐ Difficulty conceiving	**Past Now** ☐ ☐ Endometriosis ☐ ☐ Fibroids ☐ ☐ Genital pain, swelling or itching ☐ ☐ Heavy bleeding with periods ☐ ☐ Hysterectomy ☐ ☐ Menopausal symptoms ☐ ☐ Miscarriage	**Past Now** ☐ ☐ Ovaries removed ☐ ☐ Pain with intercourse ☐ ☐ Painful periods ☐ ☐ Pelvic inflammatory disease ☐ ☐ Polycystic ovary disease ☐ ☐ Premenstrual tension / PMS ☐ ☐ Vaginal discharge or dryness

Are you currently pregnant or trying to become pregnant?

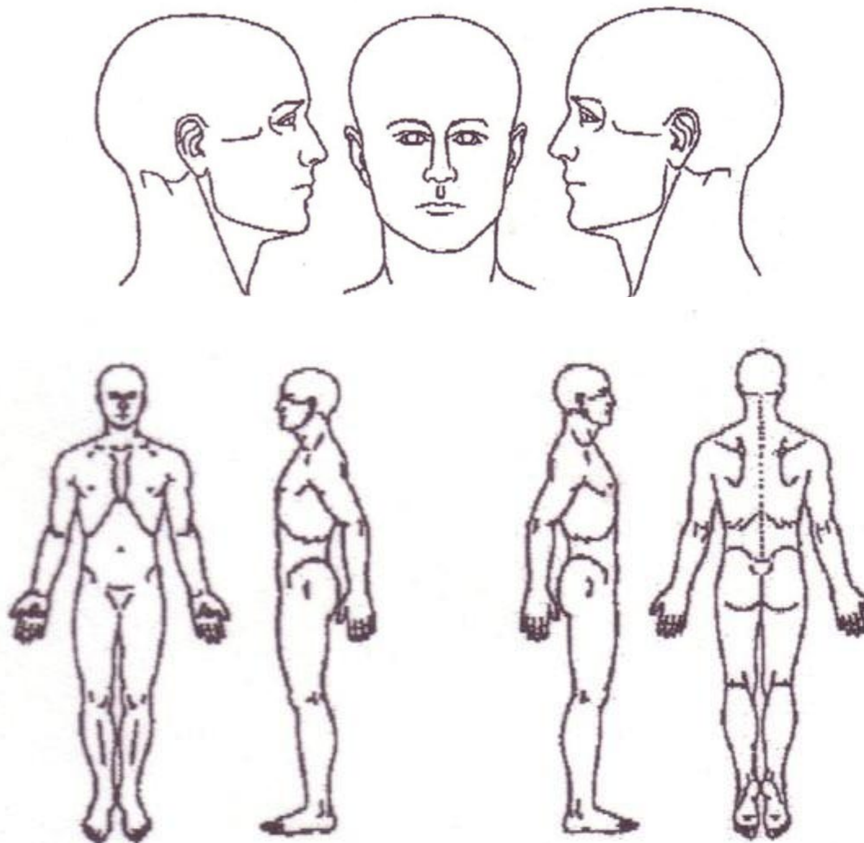
Duration of periods:	Number of pregnancies you've had:
Interval between periods (onset to onset):	Number of births you've had:
Dates of last period:	Ages of your children:
Past birth control methods:	Current birth control method:

Check if you have or had any of these:

Past Now ☐ ☐ Addiction (to ____________) ☐ ☐ AIDS / HIV ☐ ☐ Allergies (to _____________) ☐ ☐ Anemia ☐ ☐ Arthritis ☐ ☐ Asthma ☐ ☐ Bleeding disorder ☐ ☐ Blood clots ☐ ☐ Bronchitis ☐ ☐ Cancer / tumor ☐ ☐ Cataracts ☐ ☐ Chicken pox ☐ ☐ Chronic fatigue syndrome ☐ ☐ Colon / bowel disease ☐ ☐ Diabetes ☐ ☐ Emotional / mental illness ☐ ☐ Emphysema	**Past Now** ☐ ☐ Epilepsy / Seizure disorder ☐ ☐ Gall bladder disease / stones ☐ ☐ Glaucoma ☐ ☐ Gout ☐ ☐ Gum disease ☐ ☐ Heart disease ☐ ☐ Hepatitis or jaundice ☐ ☐ Herpes ☐ ☐ High / Low blood pressure ☐ ☐ High cholesterol ☐ ☐ Kidney stones ☐ ☐ Kidney or bladder infection ☐ ☐ Liver disease ☐ ☐ Lupus ☐ ☐ Malaria ☐ ☐ Measles, Mumps or Rubella ☐ ☐ Mononucleosis	**Past Now** ☐ ☐ Multiple sclerosis ☐ ☐ Osteoporosis / osteopenia ☐ ☐ Pacemaker ☐ ☐ Parkinson's ☐ ☐ Pneumonia ☐ ☐ Polio ☐ ☐ Rheumatic or Scarlet fever ☐ ☐ Shingles ☐ ☐ Spinal meningitis ☐ ☐ Stroke ☐ ☐ Tuberculosis ☐ ☐ Thyroid trouble or goiter ☐ ☐ Ulcer ☐ ☐ Varicose veins ☐ ☐ Venereal disease Other:

Surgeries, hospitalizations & dates:	Accidents, injuries & dates:	Medications, reasons & dosages:
		______________________________
		______________________________
		______________________________
		______________________________
		______________________________
		______________________________
		______________________________

Please Indicate Areas of Pain or Discomfort:



Severity	**Severity**
☐Back pain or trouble ----------------1 2 3 4 5	☐Spinal disc problems ------------ 1 2 3 4 5
☐Muscle pain, spasm, cramping - 1 2 3 4 5	☐Stiff or painful neck ------------ 1 2 3 4 5
☐Muscle weakness------------------- 1 2 3 4 5	☐Swelling --------------------------- 1 2 3 4 5
☐Restless or nervous legs----------- 1 2 3 4 5	☐Tendonitis (where:________________________)

Please describe your pain/discomfort: __________ __________ __________ __________ __________ ________	
Is there anything else you need to tell us?	
By signing, I attest that all information I have provided on this Health History is true, accurate and complete. I understand that if I wish to change the dosages of my medications, K. Planinz recommends that this happen gradually and with consent of my prescribing physician(s). I know K. Planinz does not treat cancer or epilepsy.	
Sign:	**Date:**