AcuBar LA

Date: _____

PATIENT INFORMATION

Name _____ Birthdate _____

Health History Questionnaire

Major Complaints (please list in the order of significance)

1		How Long
2		How Long
3		How Long
4		How Long
5		How Long

	Recent Tests	Date	Test Results
	Physical		
	Blood		
	Urine		
	Cholesterol		
	Thyroid		
	Pap Smear		
	Mammography		
	Prostate		
	MRI		
	X-ray		
	CT Scan		

Medication(s) you are currently taking

	Name	Reason	Dosage	Start Date
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Health History Questionnaire

Supplement(s) you are currently taking

	Name	Reason	Dosage	Start Date
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Overview of Symptoms

A = Acute (less than 3 months)
C = Chronic (more than 3 months)
F = Frequently Experienced

INTEGUMENTARY							
Rash / Lesion	☐ A	☐ C	☐ F	Itchy	☐ A	☐ C	☐ F
Hives	☐ A	☐ C	☐ F	Warts / Moles	☐ A	☐ C	☐ F
Psoriasis / Eczema	☐ A	☐ C	☐ F	Perspiration	☐ A	☐ C	☐ F
Dry	☐ A	☐ C	☐ F	Never sweat	☐ A	☐ C	☐ F
Cancer	☐ A	☐ C	☐ F	Unusual sweating	☐ A	☐ C	☐ F
Changes in skin color	☐ A	☐ C	☐ F	Non-healing wounds	☐ A	☐ C	☐ F
Changes in hair	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Changes in nails	☐ A	☐ C	☐ F				
Lump	☐ A	☐ C	☐ F				

MUSCULOSKELETAL							
Weakness	☐ A	☐ C	☐ F	Pain : Low Back	☐ A	☐ C	☐ F
Stiffness	☐ A	☐ C	☐ F	Pain : Shoulder	☐ A	☐ C	☐ F
Tremors	☐ A	☐ C	☐ F	Pain : Elbow	☐ A	☐ C	☐ F
Arthritis	☐ A	☐ C	☐ F	Pain : Wrist	☐ A	☐ C	☐ F
Spasms / Cramps	☐ A	☐ C	☐ F	Pain : Hand	☐ A	☐ C	☐ F
Joint clicking	☐ A	☐ C	☐ F	Pain : Hip	☐ A	☐ C	☐ F
Movement Limitation	☐ A	☐ C	☐ F	Pain : Knee	☐ A	☐ C	☐ F
Swelling	☐ A	☐ C	☐ F	Pain : Ankle	☐ A	☐ C	☐ F
Pain : Full body	☐ A	☐ C	☐ F	Pain : Foot	☐ A	☐ C	☐ F
Pain : Facial (e.g. jaw)	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Pain : Neck	☐ A	☐ C	☐ F				
Pain : Upper Back	☐ A	☐ C	☐ F				
Pain : Mid Back	☐ A	☐ C	☐ F				

HEAD							
Headache	☐ A	☐ C	☐ F	Head injury	☐ A	☐ C	☐ F
Dandruff	☐ A	☐ C	☐ F	Hair loss	☐ A	☐ C	☐ F
Oily / Dry hair	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Migraine	☐ A	☐ C	☐ F				

EYES							
Dry / Watery	☐ A	☐ C	☐ F	Discharge	☐ A	☐ C	☐ F
Double Vision	☐ A	☐ C	☐ F	Dark under eyelid	☐ A	☐ C	☐ F
Glaucoma	☐ A	☐ C	☐ F	Loss Vision	☐ A	☐ C	☐ F
Strain	☐ A	☐ C	☐ F	Eye pain	☐ A	☐ C	☐ F
Itchy	☐ A	☐ C	☐ F	Redness	☐ A	☐ C	☐ F
Blurry Vision	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Cataracts	☐ A	☐ C	☐ F				
Styes	☐ A	☐ C	☐ F				

EARS							
Discharge	☐ A	☐ C	☐ F	Ringing / Buzzing	☐ A	☐ C	☐ F
Itchy	☐ A	☐ C	☐ F	Balance problems (vertigo)	☐ A	☐ C	☐ F
Pain / Infections	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Hearing loss	☐ A	☐ C	☐ F				

NOSE / MOUTH / THROAT							
Frequent Colds	☐ A	☐ C	☐ F	Canker sores	☐ A	☐ C	☐ F
Congestion	☐ A	☐ C	☐ F	Sore throat	☐ A	☐ C	☐ F
Polyps	☐ A	☐ C	☐ F	Cold sores	☐ A	☐ C	☐ F
Nosebleeds	☐ A	☐ C	☐ F	Gum disease	☐ A	☐ C	☐ F
Post nasal drip	☐ A	☐ C	☐ F	Dentures	☐ A	☐ C	☐ F
Seasonal Allergies	☐ A	☐ C	☐ F	Tastes loss	☐ A	☐ C	☐ F
Olfaction impaired	☐ A	☐ C	☐ F	Cavities	☐ A	☐ C	☐ F
Stuffiness	☐ A	☐ C	☐ F	Hoarsness	☐ A	☐ C	☐ F
Sinus problems	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F

NECK							
Stiffness	☐ A	☐ C	☐ F	Tension	☐ A	☐ C	☐ F
Full movement	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Swollen glands	☐ A	☐ C	☐ F				

RESPIRATORY							
Cough	☐ A	☐ C	☐ F	Asthma	☐ A	☐ C	☐ F
Breath shortness : Exertion	☐ A	☐ C	☐ F	Painful breathing	☐ A	☐ C	☐ F
Breath shortness : Sitting	☐ A	☐ C	☐ F	Chest pain / tightness	☐ A	☐ C	☐ F
Breath shortness : Lying down	☐ A	☐ C	☐ F	Skin bluish discoloration	☐ A	☐ C	☐ F
Wheezing	☐ A	☐ C	☐ F	Coughing up blood	☐ A	☐ C	☐ F
Tuberculosis	☐ A	☐ C	☐ F	Sputum production	☐ A	☐ C	☐ F
Bronchitis	☐ A	☐ C	☐ F	Voice changes	☐ A	☐ C	☐ F
Pneumonia	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F

CARDIOVASCULAR							
High Blood Pressure	☐ A	☐ C	☐ F	Skin temperature changes	☐ A	☐ C	☐ F
Low Blood Pressure	☐ A	☐ C	☐ F	Fainting (Syncope)	☐ A	☐ C	☐ F
Arrhythmias	☐ A	☐ C	☐ F	Fatigue	☐ A	☐ C	☐ F
Edema	☐ A	☐ C	☐ F	Skin ulceration	☐ A	☐ C	☐ F
Rheumatic Fever	☐ A	☐ C	☐ F	Ankles / legs swelling	☐ A	☐ C	☐ F
Murmurs	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Palpitations	☐ A	☐ C	☐ F				
Chest pain	☐ A	☐ C	☐ F				

DIGESTIVE / GASTROINTESTINAL							
Abdominal distention / bloating	☐ A	☐ C	☐ F	Indigestion	☐ A	☐ C	☐ F
Abdominal mass	☐ A	☐ C	☐ F	Jaundice	☐ A	☐ C	☐ F
Abdominal pain	☐ A	☐ C	☐ F	Nausea	☐ A	☐ C	☐ F
Heartburn	☐ A	☐ C	☐ F	Vomiting	☐ A	☐ C	☐ F
Alternating Constipation / Diarrhea	☐ A	☐ C	☐ F	Change in appetite	☐ A	☐ C	☐ F
Rectal bleeding	☐ A	☐ C	☐ F	Pancreatitis	☐ A	☐ C	☐ F
Blood in stool	☐ A	☐ C	☐ F	Liver disease	☐ A	☐ C	☐ F
Parasites	☐ A	☐ C	☐ F	Gall bladder disease	☐ A	☐ C	☐ F
Constipation	☐ A	☐ C	☐ F	Ulcer	☐ A	☐ C	☐ F
Diarrhea	☐ A	☐ C	☐ F	IBS	☐ A	☐ C	☐ F
Gas	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Eating disorder	☐ A	☐ C	☐ F				

UROGENITAL							
Incontinence	☐ A	☐ C	☐ F	Discharge / Blood	☐ A	☐ C	☐ F
Frequent infections	☐ A	☐ C	☐ F	Rashes	☐ A	☐ C	☐ F
Urgency	☐ A	☐ C	☐ F	Urinary tract infection	☐ A	☐ C	☐ F
Painful urination	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Kidney Stones	☐ A	☐ C	☐ F				

NEUROLOGICAL							
Paralysis	☐ A	☐ C	☐ F	Gait disturbance	☐ A	☐ C	☐ F
Tingling / Numbness	☐ A	☐ C	☐ F	Headache	☐ A	☐ C	☐ F
Seizures	☐ A	☐ C	☐ F	Loss of consciousness	☐ A	☐ C	☐ F
Sciatica	☐ A	☐ C	☐ F	Post shingles pain	☐ A	☐ C	☐ F
Carpal tunnel	☐ A	☐ C	☐ F	Movement problems	☐ A	☐ C	☐ F
Fainting	☐ A	☐ C	☐ F	Severe forgetfulness	☐ A	☐ C	☐ F
Consciousness changes	☐ A	☐ C	☐ F	Tremor	☐ A	☐ C	☐ F
Confusion	☐ A	☐ C	☐ F	Visual disturbance	☐ A	☐ C	☐ F
Difficulty concentrating	☐ A	☐ C	☐ F	Weakness	☐ A	☐ C	☐ F
Dizziness	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Dysphasia	☐ A	☐ C	☐ F				

PSYCHOLOGICAL							
Depression	☐ A	☐ C	☐ F	Grief	☐ A	☐ C	☐ F
Suicidal	☐ A	☐ C	☐ F	Sadness	☐ A	☐ C	☐ F
Anxiety	☐ A	☐ C	☐ F	Anxious / Nervous	☐ A	☐ C	☐ F
Eating disorder	☐ A	☐ C	☐ F	Manic	☐ A	☐ C	☐ F
PTSD	☐ A	☐ C	☐ F	Worried / Overly pensive	☐ A	☐ C	☐ F
Anger / Irritability	☐ A	☐ C	☐ F	Overwhelmed	☐ A	☐ C	☐ F
High strung / tense	☐ A	☐ C	☐ F	Extreme mood swings	☐ A	☐ C	☐ F
Fear / Panic	☐ A	☐ C	☐ F	Extreme lack of emotion	☐ A	☐ C	☐ F
Psych hospitalization	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Brain Fog	☐ A	☐ C	☐ F				

MISCELLANEOUS / SLEEP							
Night Sweats	☐ A	☐ C	☐ F	Thirsty	☐ A	☐ C	☐ F
Spontaneous sweat	☐ A	☐ C	☐ F	Hemorrhoids	☐ A	☐ C	☐ F
Easily awaken	☐ A	☐ C	☐ F	Bitter tasting mouth	☐ A	☐ C	☐ F
Foul breath	☐ A	☐ C	☐ F	Oversleep	☐ A	☐ C	☐ F
Bruise easily	☐ A	☐ C	☐ F	Ringing ears	☐ A	☐ C	☐ F
Excessive dreaming	☐ A	☐ C	☐ F	Difficulty falling asleep	☐ A	☐ C	☐ F
Brittle nail	☐ A	☐ C	☐ F	Dream disturbed sleep	☐ A	☐ C	☐ F
Sigh easily	☐ A	☐ C	☐ F	Sleep problems	☐ A	☐ C	☐ F
Cold hands / feet	☐ A	☐ C	☐ F	Extremely low energy	☐ A	☐ C	☐ F
Phlegm	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Loss of voice	☐ A	☐ C	☐ F				

FOR WOMEN ONLY							
Abnormal vaginal bleeding	☐ A	☐ C	☐ F	Pelvic pain	☐ A	☐ C	☐ F
Changes in hair distribution	☐ A	☐ C	☐ F	PMS	☐ A	☐ C	☐ F
Fertility concerns	☐ A	☐ C	☐ F	Sexual dysfunction	☐ A	☐ C	☐ F
Irregular menstruation	☐ A	☐ C	☐ F	Unusual discharge	☐ A	☐ C	☐ F
Menopausal symptoms	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Pain with menses	☐ A	☐ C	☐ F				
Pain with intercourse	☐ A	☐ C	☐ F				

Are you pregnant OR trying to become pregnant?

YES ☐ NO ☐

Have you ever been pregnant? If yes, how many pregnancies : _____

YES ☐ NO ☐

Births _____

Miscarriages _____

Abortions _____

FOR MEN ONLY							
Fertility concerns	☐ A	☐ C	☐ F	Unusual discharge	☐ A	☐ C	☐ F
Prostate problems	☐ A	☐ C	☐ F	Other (please list)	☐ A	☐ C	☐ F
Sexual dysfunction	☐ A	☐ C	☐ F				

PAIN

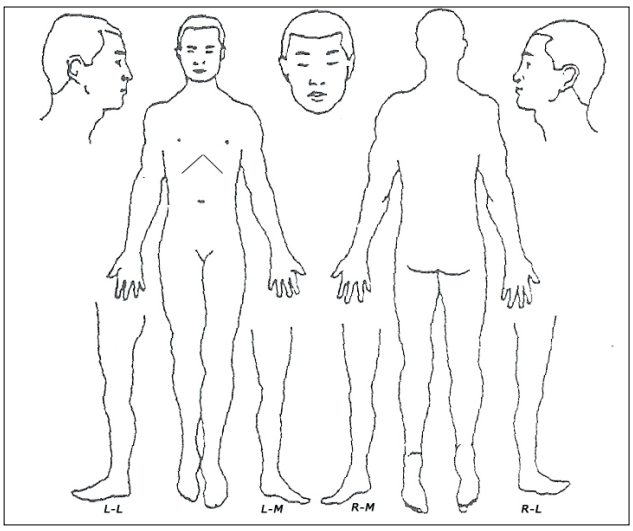
What makes the pain better?

- ☐ Soft Pressure
- ☐ Hard Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other

What makes the pain worse?

- ☐ Soft Pressure
- ☐ Hard Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other

On the figures below, please mark clearly any area of pain a x and indicate any scars with line.



Comments: _____

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