



Kristi Stoddard, L.Ac. 5417 Ivanhoe Place NE Seattle, WA 98105 206-335-0895

Health History Questionnaire

Name:	Date of Birth:	Sex:	Date:
Address:	City:	State:	Zip:
Home Phone:	Emergency Contact Name:	Emergency Contact Phone:	
Employer (if applicable):	Phone # to Reach You During the Day:	E-mail:	
Primary Physician:	Referred by:	Marital Status:	

What is the main reason for your visit today?

Diagnosis of problem, if available:

How severe is the problem now? (Rank on scale below)
 No problem _____ Worst Imaginable

What other health concerns do you have?

List surgeries you have had and approximate dates:

Major accidents & illnesses:

Allergies & type of reaction (to drugs, chemicals, foods):

Medications, herbs, and supplements you currently take:

Do you have, or have you had, any of the following:

Pacemaker HIV/AIDS Epilepsy Hepatitis Cancer Ulcers A pacemaker Herpes

Diabetes Stroke Thyroid Condition Osteoporosis Multiple Sclerosis

Financial Agreement & Authorization for Treatment

I, the undersigned, have insurance coverage with (name of the insurance company or write "none" if uninsured, or if your insurance does not cover acupuncture) _____ and assign directly to Kristi Stoddard, L.Ac. all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian/Patient _____ Date _____

If you are unable to keep your appointment for any reason, I ask that you contact me at least 3 working days in advance to cancel or reschedule the appointment. Otherwise you will be charged \$75 for the missed appointment.

Review of Systems

Please check the box if you have experienced any of these symptoms in the last two to three months.

General

- Weight loss/ gain
- Eating disorder
- Appetite change
- Tiredness, weakness
- Sudden energy drop
time of day? ____
- Fever
- Sweating at night
- Sweating when tired
- Bleeding tendency
- Bruise easily
- Poor sleep
- Strong thirst (for hot or cold?)
- Cravings

E.E.N.T.

- Disturbances of vision
- Red or itchy eyes
- Spots in front of eyes
- Loss of hearing
- Ringing in ears
- Pain in ears
- Disturbances of Speech
- Trouble Swallowing
- Sore or dry throat
- Lip or mouth sores
- Nosebleeds
- Sinus congestion
- TMJ
- Loss of taste or smell
- Headache
- Problems with teeth/dentures

Respiratory System

- Cough
- Asthma
- Chest pain
- Shortness of breath
- Rib pain

Gastrointestinal System

- Constipation
- Diarrhea
- Blood in stool
- Hemorrhoids
- Nausea, vomiting
- Heartburn
- Indigestion
- Abdominal pain/discomfort
- Gas and Bloating
- Jaundice (yellowing of skin and eyes)

Genitourinary System

- Pain on urination
- Urgency to urinate
- Blood in urine
- Frequent urination
- Incontinence
- Kidney stones
- Impotency
- Change of sexual drive
- Sexually transmitted disease
- Hernia

Gynecology & Pregnancy

- # of pregnancies _____
- # of births _____
- Age at first menses _____
- Length of cycle _____
- PMS
- Painful periods
- Irregular Periods
- Excessive bleeding
- Light periods
- Clots in menstrual blood
- Menopause: Age _____
- Hot flashes
- Vaginal dryness
- Painful breasts
- Lumps in breasts
- Birth control pills

Musculoskeletal System

- Joint pain, swelling
- Pain in neck, shoulder, back,
arm, hand, hip, buttock, leg,
knee, ankle, foot (please circle)
- Cold hands or feet
- Pins & needles sensation

Cardiovascular System

- Palpitations
(sudden, episodic strong heart beats)
- Blood pressure problems
- High cholesterol
- History of heart murmurs
- Swollen ankles or feet
- Blood clots

Central Nervous System

- Fainting
- Convulsions
- Weakness / paralysis
- Loss of feeling or function in
body part.
- Disturbances of balance
- Dizziness
- Light-headedness

Emotional

- Worry
- Moodiness
- Irritability
- Nervousness
- Depression
- Grief
- Problems in relationships

Skin and Hair

- Rash
- Oozing skin sores
- Eczema
- Loss of hair

Are you on a restricted diet? If so, please describe: _____