Date:

HEALTH HISTORY QUESTIONNAIRE

FUNCTIONAL WELLNESS & ACUPUNCTURE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. Please bring this questionnaire along with any recent medical tests to your initial appointment.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Address:	
Home Phone:	**Cell Phone:**
Email:	☐ Yes it is ok to email clinic updates. Your e-mail will be kept private.
Guardian & Phone (if under 18):	

Height:	**Weight:**	**Blood Type:**
Occupation:	**Employer:**	
Employer Address:		
Emergency Contact:	**Relationship:**	
Emergency Contact Cell Phone:	**Emergency Contact Other Phone:**	
How were you referred to FWC?		
Primary Care Physician:	**Phone:**	
Address:		
Prescription Medications Taken with Name of Prescribing Physician		
OTC Medications & Dietary Supplements Used		
Other Health Care Providers Regularly Seen		

Name & Type	**Phone Number**	**Reason For Visits**

Major Health Issues to be Addressed in Order of Significance

Health Issue/Doctor Diagnosed	**Severity**	**Description**
☐ Y ☐ N		
☐ Y ☐ N		
☐ Y ☐ N		
☐ Y ☐ N		
☐ Y ☐ N		
☐ Y ☐ N		

Further Details of Major Health Issues (How Long, Past Treatment Approaches, How Life is Impacted, What Makes Better/Worse)

Please List All Allergies to Medications, Foods or Inhalants:

PERSONAL HEALTH HISTORY

Please describe your childhood health:

Surgeries & Other Hospitalizations

Year	Reason	Hospital

Recent Medical Tests (Please Feel Free to Attach a Copy)

Date	Test	Results

Have you ever had a blood transfusion? ☐ Yes ☐ No

Check Any of the Following that You have Had or Currently Have

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Emphysema
☐ Heart Disease	☐ CVA (stroke)	☐ Stomach Ulcers	☐ Bleeding Tendency
☐ Asthma	☐ Pneumonia	☐ Constipation	☐ High Blood Pressure
☐ Jaundice	☐ Arthritis	☐ Diarrhea	☐ Multiple Sclerosis
☐ STD(s)	☐ Measles	☐ Other GI Problems	☐ Mononucleosis
☐ Meningitis	☐ AIDS/HIV	☐ Tuberculosis	☐ Rheumatic Fever
☐ Epilepsy	☐ Hepatitis	☐ Headaches/Migraines	☐ Lyme/Tickborne Disease
☐ Paralysis	☐ Cancer	☐ Thyroid Disorders	☐ Autoimmune Disease

☐ Other (please list)

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS SECTION ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Briefly describe your diet and eating habits:			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	How much & how often?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	How much & how often?			
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
	How much & how often?			
Cortisone or Prednisone	Have you ever taken?		☐ Yes	☐ No
	How much and for how long?			
Antibiotics	Have you had more had more than 2 courses in your lifetime?		☐ Yes	☐ No
	Approximately how many?			
Dental	Do you have silver amalgam fillings?		☐ Yes	☐ No
	Approximately how many?			
Birth History	Unusual (prolonged labor, forceps delivery, C-section)		☐ Yes	☐ No
	Please Explain?			
Environmental Exposures	Have you had any known exposures to chemicals, molds, radiation, heavy metals etc.?		☐ Yes	☐ No
	Please Explain?			
Sleep	Bed Time	Time Arise	# of Wake Ups	
Computer & WiFi	Do you believe that you are hypersensitive to computers or WiFi?		☐ Yes	☐ No

Check Any of the Following Vaccinations that You have Had

☐ Tetanus	☐ Smallpox	☐ Diphtheria	☐ Polio
☐ Pertussis	☐ Rubella	☐ Measles	☐ Influenza
☐ Hepatitis B	☐ HPV	☐ Chickenpox/Shingles	☐ Other

Which vaccinations have you had in the past year?

Where have you traveled outside of the USA?

FAMILY HEALTH HISTORY

	AGE/AGE LIVED TO	SIGNIFICANT HEALTH PROBLEMS		AGE/AGE LIVED TO	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Check If Any of the Following have Occurred in Your Blood Relatives

☐ Diabetes	☐ Allergies	☐ Kidney Disease	☐ Tuberculosis
☐ Heart Disease	☐ CVA (stroke)	☐ Stomach Ulcers	☐ Cancer
☐ Asthma	☐ Nervous System Ailment	☐ Alcoholism	☐ High Blood Pressure
☐ Bleeding Tendency	☐ Arthritis	☐ Obesity	☐ Mental Illness
☐ Other			

MENTAL HEALTH

With whom do you live? (Include children, parents, partners, relatives, friends, pets and their ages)

Have you ever been emotionally, physically or sexually abused?

Have you ever been treated for anxiety, depression or other emotional issues?

Do you have problems with your appetite or over eating?

Have you had any recent stressful experiences (divorce, death of a loved one, loss of job, illness, injury, finances etc.)?

Is there an ongoing stress in your life, at work, with family, etc.?

PATIENT SYMPTOMS

Pain

Describe where your pain is and check any of the following that apply:

☐ Sharp	☐ Burning	☐ Aching
☐ Cramping	☐ Dull	☐ Moving
☐ Fixed	☐ Better with Pressure	☐ Worse with Pressure
☐ Better with Cold	☐ Worse with cold	☐ Better with Heat
☐ Better with Heat	☐ Other	

General

☐ Head or Chest Cold	☐ Often Thirsty	☐ Chills
☐ Perspire Easily w/o Exertion	☐ Anemia	☐ Flu symptoms
☐ Fatigued Easily	☐ Recent Weight Gain	☐ Rarely Perspire
☐ Seldom Thirsty	☐ Recent Weight Loss	☐ Jaundice
☐ Night Sweats	☐ Sudden Drop in Energy	☐ Anxious
☐ Always Fatigued	☐ Recurrent Fever	☐ Depressed

Head, Ears, Nose, Mouth, Throat

☐ Frequent Colds	☐ Headache	☐ Decreased Sense of Smell
☐ Sinus Congestion or Pain	☐ Migraine Headache	☐ Dry Mouth
☐ Facial Pain	☐ Congestion in Ears	☐ Excessive Saliva or Drooling
☐ Jaw tension, clicking, TMJ	☐ Earache	☐ Sores on Tongue
☐ Grinding Teeth	☐ Tinnitus (Ear Ringing)	☐ Sores in Mouth
☐ Frequent Dental Cavities	☐ Difficulty Hearing	☐ Sores on Lips
☐ Gum Issues	☐ Deafness	☐ Difficulty Swallowing
☐ Bleeding Gums	☐ Nasal Congestion	☐ Lump or Pit in Throat
☐ Dentures	☐ Runny Nose	☐ Sore Throat
☐ Dizziness, Vertigo, Loss of Balance	☐ Nose Bleeds	☐ Strep Throat
☐ Concussion	☐ Sneezing	☐ Swollen Lymph Nodes
☐ Seizures	☐ allergies	☐ Tonsillitis

Eyes

☐ Nearsighted	☐ Sensitivity to Light	☐ Watery Eyes
☐ Farsighted	☐ Blurred Vision	☐ Itchy Eyes
☐ Astigmatism	☐ Floating Spots	☐ Red Eyes
☐ Glaucoma	☐ Pressure Behind Eyes	☐ Conjunctivitis
☐ Cataracts	☐ Eye Pain	☐ Use Eyeglasses or Contacts
☐ Night Blindness	☐ Dry Eyes	☐ Blindness

Respiratory

☐ Chronic Cough	☐ Clear or White Phlegm	☐ Shortness of Breath
☐ Dry Cough	☐ Yellowish Phlegm	☐ Emphysema
☐ Tight, Rattling Cough	☐ Blood Tinged Phlegm	☐ Wheezing
☐ Loose Cough	☐ Bronchitis	☐ Asthma: more difficult exhale
☐ Thick, Sticky Phlegm	☐ Pneumonia	☐ Asthma: more difficult inhale
☐ Thin, Watery Phlegm	☐ Pain with Deep Breath	☐ Asthma: worse on exhale

Cardiovascular

☐ High Blood Pressure	☐ High Cholesterol or Triglycerides	☐ Swelling of Hands
☐ Low Blood Pressure	☐ Stroke	☐ Swelling of Feet
☐ Blackouts or Fainting	☐ Blood Clot	☐ Cold Hands
☐ Arrhythmia (Irregular Heart Beat)	☐ Phlebitis	☐ Cold Feet
☐ Heart Valve Issue, Murmur	☐ Varicose Veins	☐ Hot Hands or Palms
☐ Tachycardia, Palpitations	☐ Bruise Easily	☐ Hot Feet or Soles
☐ Angina or Chest Pain	☐ Anemia	☐ Generally too Hot
☐ Coronary Artery Disease	☐ Edema	☐ Generally too Cold

Gastrointestinal

☐ Constipation	☐ Stomach Ulcers	☐ Excessive Gas (Flatulence)
☐ Diarrhea	☐ Acid Reflux or GERD	☐ Anal or Rectal Itching
☐ Bloating within a few hours after meals	☐ Greasy, floating Stools (Steatorrhea)	☐ Excessive Appetite
☐ Hard Stools Difficult to Pass	☐ Phlebitis	☐ Poor Appetite
☐ Hemorrhoids	☐ Indigestion	☐ Bowel Movements Feel Incomplete
☐ Frequent Laxative Use	☐ Blood in the Stool	☐ Urgent Bowel Movements
☐ Diverticulosis/Diverticulitis	☐ Upper Abdominal Pain or Cramping	☐ Fecal Incontinence
☐ Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis)	☐ Lower Abdominal Pain or Cramping	☐ Hiatal Hernia
☐ IBS (Inflammatory Bowel Syndrome)	☐ Nausea	☐ Parasites
☐ Black Tarry Stool	☐ Vomiting	☐ Gurgling in Stomach
☐ Frequent Belching	☐ Mucus in the Stool	☐ Bad Breath
How often do you have a bowel movement?		
What is the consistency of your bowel movements?		

Urinary and Genital

☐ Scanty Amount of Urine	☐ Pain or Burning Urination	☐ Frequent Urination
☐ Flow does not Stop Quickly	☐ Blood in Urine	☐ Sores on the Genitals
☐ Excessive Sexual Energy	☐ Kidney Stones	☐ Strong Smelling Urine
☐ Low Sexual Energy	☐ Pain During Intercourse	☐ Cloudy Urine
☐ Urgency to Urinate	☐ Inability to Achieve Orgasm	☐ Kidney or Bladder Infection
☐ Profuse Amount of Urine	☐ Pain in the Bladder Area	☐ Dark Urine
How often do you urinate in 24 hours?	How often do you wake to urinate at night?	

Skin and Hair

☐ Rashes	☐ Acne	☐ Moist Feet
☐ Hives	☐ Ulcerations or Sores	☐ Moist Hands
☐ Itching	☐ Moles	☐ Fungus on Skin
☐ Eczema	☐ Recent Changes in Moles	☐ Fungus under Nails
☐ Psoriasis	☐ Warts	☐ Weak or Brittle Nails
☐ Herpes Zoster (Shingles)	☐ Dry Skin	☐ Loss of Hair
☐ Boils	☐ Dry or Brittle Hair	☐ Dandruff
Any numb areas?	If so, where?	
Any scars?	If so, where?	

Sleep Hygiene

☐ Difficulty Falling Asleep (Wired)	☐ Sleep too Much	☐ Sleep with Electric Blanket or Waterbed
☐ Difficulty Staying Asleep	☐ Wake Up at Night Thinking	☐ Sleep with WiFi On
☐ Snoring	☐ Sleepy in Afternoon	☐ Shallow Sleep
☐ Insufficient Sleep	☐ Need to Nap	☐ Difficulty Waking in Morning
☐ Wake Up at Night, Mind Empty, Eyes Open	☐ Sleep Disturbed by Dreams	☐ Altered Sleeping Schedule (Shift Work)
☐ Nightmares	☐ Wake Up Unrefreshed	☐ Narcolepsy
Hours Slept per Night	Normal Bed Time	Normal Time Awake

Emotional

☐ Depression	☐ Anxiety or Fear	☐ Difficulty Handling Stress/Overwhelmed
☐ Manic Episodes	☐ Sadness or Grief	☐ Suicidal Feelings
☐ Indecisiveness	☐ Frequent Crying	☐ Obsessions or Compulsions
☐ Mood Swings	☐ Frequent Anger or Irritation	☐ Tendency to Repress Emotions

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days; Period lasts _____ days		
Heavy periods, irregularity, spotting, pain, cramps, clots or discharge?	☐ Yes	☐ No
Please provide details:		
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, oophorectomy, difficult delivery or Cesarean?	☐ Yes	☐ No
Please provide details:		
Have you ever had an abnormal PAP or been diagnosed with endometriosis, uterine fibroids, ovarian cysts or pelvic inflammatory disease?	☐ Yes	☐ No

Please provide details:		
Do you currently or have you previously used birth control pills?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Are you currently nursing?	☐ Yes	☐ No
Are you trying to become pregnant?	☐ Yes	☐ No
Do you suspect that you have fertility issues?	☐ Yes	☐ No
Have you ever suffered a miscarriage?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Do you have problems starting the flow of urine or with dribbling urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No
Do you have a low sperm count?	☐ Yes	☐ No

The information provided in this Health History is true to the best of my knowledge.

I understand and accept that I am responsible for full payment of my account and that payment is due at the time that service is provided.

I also understand and accept that I am expected to notify FWA 24 hours prior to any cancellation of or changes to my appointment time and that if I do not I am responsible for a $50 cancellation fee.

Signed _____ Date _____

Parent/Guardian (if applicable) _____