# Harmony Acupuncture and Sound Healing

Harmony Healing Center
321 Ninth St. – Leavenworth
and
304 Grant Road – East Wenatchee
886-4554

## 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**_____ **Social Security #**_____

**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 drank 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

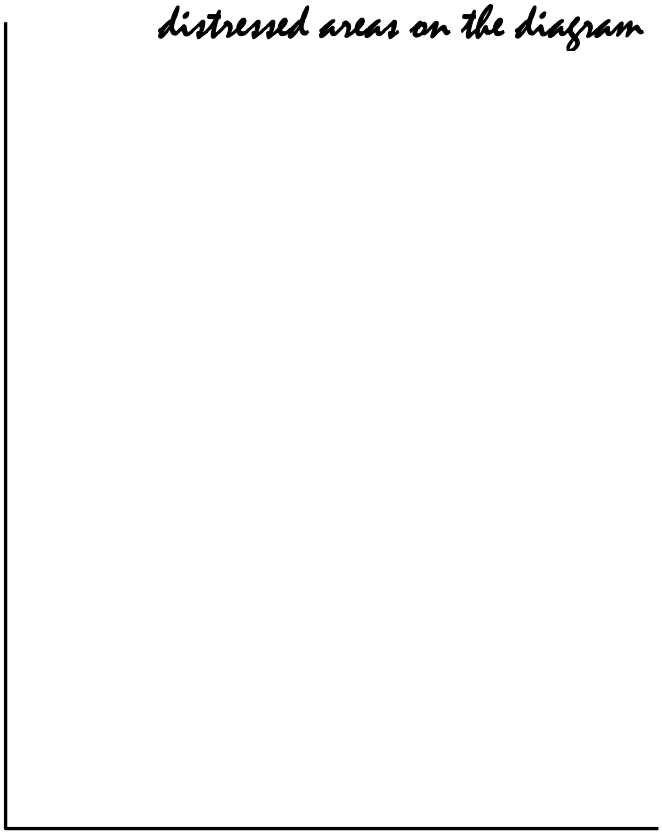
**Please list all your medications** (including sleeping pills, birth control) and non-prescription drugs (such as Aspirin, antacids, laxatives, antihistamines) that you take on a regular basis.

_____
_____
_____
_____
_____
_____

**Please list all vitamin supplements** you are taking on a regular basis and their dosage.

_____
_____
_____
_____
_____

## Please indicate painful or distressed areas on the diagram



## Family History

Place a check √ for those diseases one or both of your parents had; place a plus + for any diseases your siblings have; you may place both a check and plus if necessary.

| | | | | |
|---|---|---|---|---|
| _____ Cancer | _____ Diabetes | _____ Depression | _____ Heart Disease | _____High BP |
| _____ Stroke | _____ Epilepsy | _____Mental illness | _____Asthma | _____Kidney disease |
| _____ Glaucoma | _____ Tuberculosis | ____Thyroid disease | _____ MS | _____Neurological disease |
| Other_____ | | | _____ Autoimmune disease | |

**Please note the degree of severity of your problem now:**

**0 1 2 3 4 5 6 7 8 9 10**
Lowest Highest

**Please note the greatest degree of severity of your problem within this past week:**

**0 1 2 3 4 5 6 7 8 9 10**
Lowest Highest

*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.*