HEALTH HISTORY QUESTIONNAIRE

EnerQi Health: www.EnerQiHealth.com
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Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. Please bring this questionnaire and interpretive reports on any recent medical tests to your Initial Evaluation. <u>All information is strictly confidential.</u>

I. General Patient Information

Date: ____/____/____Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email:_____ ☐ Yes, it is ok to *occasionally* email me with clinic updates, etc. My information will remain private.

Age: _____ Date of Birth: _____/_____/_____ Place of Birth:_____

Guardian (if under 18): _____

Gender: M F Trans-gender Height: _____'_____" Weight: _____lbs.

Occupation:_____Employer:_____

Employer Address:_____City, State, Zip_____

How did you hear about EnerQi? _____

Other physicians/ therapists seen for this condition:_____

Medications (if any):_____

_____

Prescribed by:_____

Supplements (any vitamins, herbs, mineral, etc.)_____

_____

_____

Health Care Providers you regularly see (primary care, chiropractors, therapists, bodywork practitioners, etc.)

Please list names, addresses, & phone numbers: _____

_____

_____

II. Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal
1.	☐	☐	☐	☐
2	☐	☐	☐	☐
3.	☐	☐	☐	☐
4	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

How do these conditions impair your daily activities?_____

_____

_____

_____

III. Patient Medical History

Notable childhood health problems:_____

_____

Hospital Visits/ Stays:_____

_____

_____

_____

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?)

☐ HIV/STD ☐ Pap smear ☐ Mammography ☐Other:_____

Test Results and Date:_____

_____

_____

Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding tendency
☐ Syphilis	☐ Measles	☐ Chicken pox	☐ Psychological trauma
☐ Meningitis	☐ HIV	☐ Polio	☐ Mononucleosis
☐ Epilepsy	☐ High fever	☐ Hepatitis	☐ Multiple Sclerosis
☐ Paralysis	☐ Cancer	☐ Migraines	☐ High blood pressure
☐ Concussion	☐ Eye/vision problem	☐ Miscarriage	☐ Mood disorder

Other::_____

Surgeries (list type & year, date if known) _____

_____

_____

IV. Family History : (Adapt this section as needed) – If unknown, please indicate

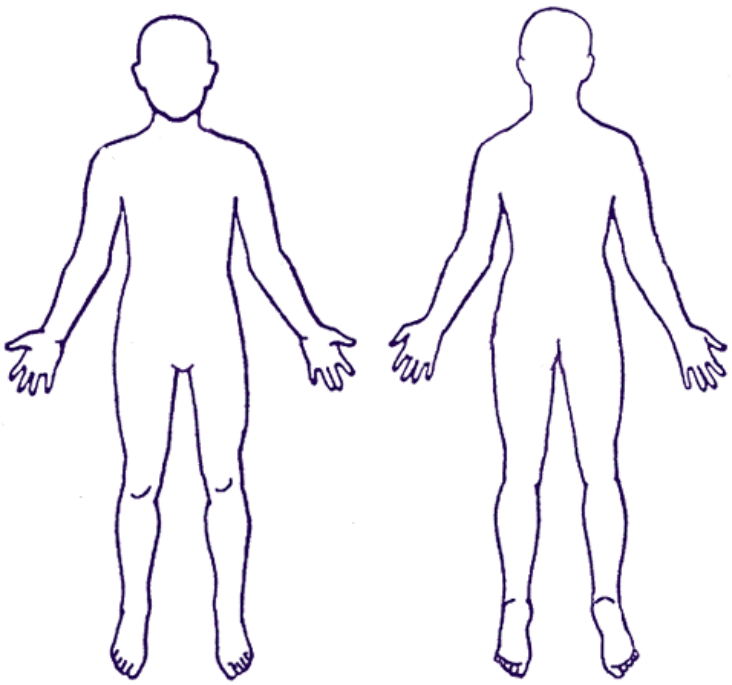
Family Member	Alive	Deceased	Present Health Issues or Cause of Death
Father	☐	☐	
Mother	☐	☐	
Father's parents	☐	☐	
Mother's parents	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Child	☐	☐	
Child	☐	☐	
Child	☐	☐	
Your partner/spouse	☐	☐	

Where are you in the birth order? ☐ First ☐ Middle ☐Last ☐ Only

Check the following that have occurred in your blood relatives:

☐ Diabetes	☐ Cancer	☐ Heart disease	☐ High blood pressure
☐ Allergies	☐ Tuberculosis	☐ Obesity	☐ Bleeding tendency
☐ Kidney disease	☐ Alcoholism	☐ Nervous illness	☐ Mental illness
☐ Stroke	☐ Other _____		

V..Patient Profile: Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the pain:
☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed ☐ Other:_____

Do the following lessen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Exercise
☐ Other:_____

Do the following worsen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Other:_____

Please check the following that currently pertain to you.

Overall Temperature (Kidney function):
☐ Cold hands
☐ Cold feet
☐ Sweaty hands
☐ Sweaty feet
☐ Hot body temperature (sensation)
☐ Cold body temperature (sensation)
☐ Afternoon flushes
☐ Night sweats
☐ Heat in the hands, feet, and chest
☐ Hot flashes any time of the day
☐ Thirsty
☐ Perspire easily
☐ Lack of perspiration
☐ Take water to bed
☐ Difficulty keeping eyes open in the daytime

Overall energy (Lung, Kidney function):
☐ Shortness of breath
☐ Difficulty keeping eyes open in the daytime
☐ General weakness
☐ Easily catch colds
☐ Low energy
☐ Feel worse after exercise

Blood (Liver, Spleen, Heart function):
☐ Dizziness
☐ See floating black spots

Heart function:
☐ Palpitations
☐ Anxiety
☐ Sores on the tip of the tongue
☐ Restlessness
☐ Mental confusion
☐ Chest pain traveling to shoulder
☐ Frequent dreams
☐ Wake unrefreshed
☐ Drink coffee (# of cups per week: _____)
☐ Insomnia

Describe:_____

Lung function:

☐ Nasal Discharge (Color: _____)
☐ Cough
☐ Nose Bleeds
☐ Sinus Congestion
☐ Dry mouth
☐ Dry throat
☐ Dry Nose
☐ Dry Skin
☐ Allergies
(To what? _____)
☐ Alternating fever and chills
☐ Sneezing
☐ Swollen glands, frequent or common symptom
☐ Overall achy feeling
☐ Stiff neck
☐ Stiff shoulders
☐ Sore throat, frequent or recurrent
☐ Difficulty breathing: worse in? or out?
☐ Smoke cigarettes
(# of cigarettes per day: _____)
☐ Sadness
☐ Melancholy

Spleen function:

☐ Low appetite
☐ Unexplained weight gain
☐ Unexplained weight loss
☐ Abdominal bloating
☐ Abdominal gas (excessive or smelly)
☐ Gurgling noise in the stomach
☐ Fatigue after eating
☐ Prolapsed organs (if previously diagnosed, which organ(s)? _____
☐ Easily bruised
☐ Hemorrhoids
☐ Pensive
☐ Over-thinking, replaying or rehearsing conversations
☐ Worry alot

Spleen, Stomach, Large Intestine, Small Intestine function:

☐ Loose
☐ Constipated
☐ Incomplete
☐ Diarrhea
☐ Blood in stools
☐ Mucous in stools
☐ Undigested food in stools

Dampness trapped in the body:

☐ General sensation of heaviness in the body
☐ Mental heaviness – thinking is an effort
☐ Mental sluggishness – poor word recall, etc.
☐ Mental fogginess – poor memory, forgetfulness
☐ Swollen hands
☐ Swollen feet
☐ Swollen joints
☐ Chest congestion
☐ Nausea
☐ Snoring or Apnea

Stomach function:

☐ Burning sensation after eating
☐ Large appetite
☐ Bad breath
☐ Mouth (canker) sores
☐ Bleeding, swollen or painful gums
☐ Heartburn
☐ Acid regurgitation
☐ Ulcer (diagnosed)
☐ Belching
☐ Hiccoughs
☐ Stomach pain
☐ Vomiting

Liver, Gall Bladder function:

☐ Alternating diarrhea and constipation
☐ Chest pain
☐ Tight sensation in the chest
☐ Bitter taste in the mouth
☐ Anger easily
☐ Frustration
☐ Depression
☐ Irritability
☐ Frequently unable to adapt to stress
(What causes the stress?
_____)
☐ Skin rashes
☐ Headache at the top of the head
☐ Tingling sensation
☐ Numbness
☐ Muscle spasms
☐ Muscle twitching
☐ Muscle cramping
☐ Seizures
☐ Convulsions
☐ Lump in the throat

☐ Neck tension
☐ Limited Range-of-Motion, Neck
☐ Shoulder tension
☐ Limited Range-of-Motion, Shoulder
☐ Drink alcohol
☐ Recreational drugs
(Which? _____,
How much per week? _____)
☐ High-pitched ringing in the ears
☐ Gall stones (history or current)
☐ Sexually transmitted disease
(Which? _____)

Eyes (Liver function):
☐ Itchy
☐ Bloodshot
☐ Hot
☐ Dry
☐ Watery
☐ Gritty
☐ Blurry vision
☐ Decreased night vision
☐ Near-sighted
☐ Far-sighted

Kidney, Urinary Bladder function:
☐ Frequent cavities
☐ Easily broken bones
☐ Sore knees
☐ Weak knees
☐ Cold sensation in the knees
☐ Low back pain
☐ Memory problems
☐ Excessive hair loss
☐ Low-pitched ringing in the ears
☐ Kidney stones
☐ Bladder infections
☐ Wake during the night twice or more to urinate
☐ Lack of bladder control
☐ Fear
☐ Easily startled

Urination:
☐ Normal color
☐ Dark yellow
☐ Clear
☐ Reddish
☐ Cloudy
☐ Scanty
☐ Profuse
☐ Strong odor
☐ Burning
☐ Painful
☐ Discharge
☐ Difficult
☐ Painful
☐ Urgent
☐ Frequent

Libido:
☐ Normal
☐ High
☐ Low

Other symptoms:_____

_____

_____

Other Comments:_____

_____

_____

_____

_____

Women: Please fill in as completely as possible:

Regular menstrual cycle? ☐ Y ☐ N Ave. Length between Periods: _____ Days of Flow: _____

Age of first menstruation:_____ Are you pregnant? ☐ Y ☐ N Number of pregnancies_____

Number of children born: ____ Age of menopause (if applicable):_____ Menopausal problems: _____

_____

Current /Prior Problems	**Severe**	**Moderate**	**Slight**	**Normal**
Vaginal Discharge	☐	☐	☐	☐
Bleeding between periods	☐	☐	☐	☐

Do you experience any of the following pre-menstrual or recurrent syndromes?

☐ Nausea ☐ Vomiting ☐ Water retention ☐ Breast swelling
☐ Food cravings ☐ Headaches ☐ Migraines ☐ Breast tenderness
☐ Depression ☐ Irritability ☐ Anxiety
☐ Other emotions:_____

☐ Dull pain, where?_____ ☐Sharp pain, where?_____

Please fill in the following menstrual chart:

Characteristics	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots? (size + color)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other (Fatigue, emotions, dizziness, headache)							

Men only:

☐ Swollen testes ☐ Testicular pain ☐ Impotence ☐ Premature ejaculation ☐ Lack of libido

☐ Feeling of coldness or numbness in external genitalia ☐ Waking frequently to urinate

☐ Dribbling after urination ☐ Other_____