Tracy Ng, LAc., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

Name: _____ Age: _____ Sex at Birth: _____

Birthdate: _____ Marital Status: _____ Height: _____ Weight: _____

Name of Family Physician: _____

Occupation: _____ Referred By: _____

Instructions: In order to carefully evaluate your condition and acquire a thorough overview of you as a unique individual, please take the time to thoughtfully complete this questionnaire.

Primary Reason(s) and Goal(s) for your Consultation and Treatment

_____

_____

Have you previously been treated by: ☐ Acupuncture ☐ Herbal Medicine ☐ Chiropractic ☐ Homeopathy ☐ Nutritional Therapy

Please check any conditions present in yourself or your family

FAMILY HISTORY	Self	Mother	Father	Sister	Brother	Grand parent	Comment
Alive	☑	☐	☐	☐	☐	☐	
In Good Health?	☐	☐	☐	☐	☐	☐	
Arthritis/Gout	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	
Emotional Disorders	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Ulcers	☐	☐	☐	☐	☐	☐	
Bleeding Disorders	☐	☐	☐	☐	☐	☐	
Weight Concerns	☐	☐	☐	☐	☐	☐	

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

Please check any illnesses which you have had

- ☐ Anemia
- ☐ Eczema
- ☐ Psoriasis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Diverticulitis
- ☐ Colitis
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Kidney Disease
- ☐ Emotional Disorders
- ☐ Stroke
- ☐ Ulcers
- ☐ Bleeding Disorders
- ☐ Weight Concerns
- ☐ Eye disease
- ☐ Gall stones
- ☐ Malaria
- ☐ Liver disease
- ☐ Yeast infection
- ☐ Neuralgia
- ☐ Pancreatitis
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Chicken pox
- ☐ Measles
- ☐ Mumps
- ☐ Jaundice
- ☐ Parasites
- ☐ Chronic fatigue syndrome
- ☐ Epstein Barr Virus
- ☐ Sexually transmitted diseases:
  - ☐ Herpes
  - ☐ Gonorrhea
  - ☐ Syphilis
  - ☐ HIV
  - ☐ HPV (Genital warts)
- ☐ Other:

_____

Diagnostic Tests - Please note the year (*if known*)

X-RAY/ULTRASOUND

- ☐ Chest
- ☐ Gallbladder
- ☐ Bone
- ☐ Kidney
- ☐ Sinus
- ☐ Spine
- ☐ Upper GI
- ☐ Lower GI

CT SCAN/MRI

- ☐ Brain
- ☐ Spine
- ☐ Bone
- ☐ Other

OTHER TESTS/EXAMS

- ☐ Thyroid Test/Exam
- ☐ Hearing Test
- ☐ Eye Exam
- ☐ Blood test
- ☐ Mammogram
- ☐ PAP Smear
- ☐ Urine Test
- ☐ Bone Density (Osteoperosis screen)
- ☐ Prostate Exam
- ☐ EKG
- ☐ EEG

Please name physicians / practitioners you are currently seeing or have seen in the past two (2) years

Name	Reason for visit	Date or age

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

Please list past illnesses, accidents, injuries or surgeries with year (*if known):*

Current prescriptions or over the counter medications:

Past use of antibiotics or steroids (prednisone, cortisone, etc.

Current vitamins, herbal, homeopathic, and natural remedies:

Are you now or have you ever taken:

- ☐ Birth control pills
- ☐ Anti-anxiety medication
- ☐ Antihistamines
- ☐ Estrogen or Progesterone
- ☐ Thyroid medication
- ☐ Chemotherapy
- ☐ Sedatives or sleeping pills
- ☐ Allergy Shots
- ☐ Radiation Therapy
- ☐ Anti-depressant medication
- ☐ Pain Medication
- ☐ Other:

Please list any known allergies (*food, drugs, pollens, animals, etc.)*

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

Lifestyle

Have you ever smoked cigarettes? _____ If yes, how long? _____ Packs per day _____

Currently smoking? _____ If yes, do you want to quit? _____

Recreational drug use _____ Past Present IV Drug Use _____

Do you drink alcohol? _____ How often? _____ Type _____

Do you drink ☐ Coffee ☐ Black tea ☐ Regular ☐ Decaf _____ Total cups per day

Hours per day spent on the following: _____ Exercise _____ TV _____ Computer _____ Yoga _____ Meditation _____ Outdoors _____ Indoors

Toxic Explosures

☐ Lead ☐ Radiation ☐ Herbicides/Pesticides

☐ Chemical Fumes ☐ Chemotherapy ☐ Tobacco

☐ Mercury (silver mercury dental fillings) ☐ Asbestos ☐ Other:

Diet

What do you eat for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you mostly ☐ cook for yourself ☐ Eat out ☐ Special Diet and if yes, why and please describe:

_____

Cravings (C) and Aversions (A)

☐C ☐A Salty ☐C ☐A Sour ☐C ☐A Sweets

☐C ☐A Bread/Pasta ☐C ☐A Oily/Fatty ☐C ☐A Iced/Cold Foods

☐C ☐A Chocolate ☐C ☐A Warm Foods ☐C ☐A Milk/Dairy

☐C ☐A Spicy ☐C ☐A Bitter ☐C ☐A Other:

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

Eating Patterns

- ☐ Weight Fluctuations
- ☐ Overeating
- ☐ Bulimia
- ☐ Food Binges
- ☐ Anorexia
- ☐ Vomit after eating
- ☐ Frequent Dieting
- ☐ Disssatisfied with current body weight
- ☐ Use of diet/appetite suppressants
- ☐ Use of frequent laxatives
- ☐ Satisfied with current body weight

Anything else you'd like to share about your eating habits or relationship with food:

Symptoms Review

Check any of the symptoms you have experienced in the past six (6) months. Please note frequency, last occurrence, duration, and any patterns.

HEAD

- ☐ Headaches
- ☐ Sore scalp/dandruff
- ☐ Loss of balance /dizziness
- ☐ Hair Loss

EARS

- ☐ Ear Pain
- ☐ Ear ringing
- ☐ Ear discharge
- ☐ Loss of balance/Dizziness

EYES

- ☐ Dry Eyes
- ☐ Inflamed eyes
- ☐ Swelling or pain
- ☐ Dark circles
- ☐ Excessive tearing
- ☐ Blurred vision
- ☐ Eye surgery

NOSE

- ☐ Poor sense of smell
- ☐ Post nasal drip
- ☐ Frequent colds
- ☐ Frequent nosebleeds
- ☐ Sinus pain / infection
- ☐ Hay fever/allergies

THIRST

- ☐ Rarely
- ☐ Excessive

Preference for

- ☐ Hot drinks
- ☐ Cold/Iced drinks
- ☐ Room temperature drinks

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Leg cramps at night
- ☐ Cold hands or feet
- ☐ Shortness of breath
- ☐ Ankle or foot swelling
- ☐ Heart attack
- ☐ Palpitations
- ☐ Bruise/bleed easily
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Tightness in chest
- ☐ Wounds heal slowly
- ☐ Irregular heart beat

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

MOUTH

- ☐ Bleeding gums
- ☐ Oral herpes (cold sore)
- ☐ Ulcers in mouth
- ☐ Dry lips
- ☐ Dry mouth
- ☐ Sore tongue
- ☐ Change in sense of taste

RESPIRATORY

- ☐ Sore throat
- ☐ Spitting up mucus often
- ☐ Bronchitis
- ☐ Blood in sputum
- ☐ Difficulty swallowing
- ☐ Pain in breathing
- ☐ Tonsillitis
- ☐ Cough/Wheezing

- ☐ Sensation as if something is caught in throat

SKIN

- ☐ Rash
- ☐ Itching
- ☐ Herpes
- ☐ Warts
- ☐ Pigment changes
- ☐ Abnormal sweating
- ☐ Acne
- ☐ Skin or nail fungus
- ☐ Dryness
- ☐ Eczema
- ☐ Psoriasis

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Pain with eating

- ☐ Nausea
- ☐ Heartburn
- ☐ Belching, Gas, or Bloating
- ☐ Vomiting
- ☐ Ulcers
- ☐ Food allergies
- ☐ Spitting up blood
- ☐ Hypoglycemia
- ☐ Sleepy after eating
- ☐ Difficulty swallowing
- ☐ Gallbladder problems
- ☐ Diarrhea
- ☐ Inflammatorybowel disease
- ☐ Undigested food in stool
- ☐ Black/tarry stools
- ☐ Dry hard stools/ constipation
- ☐ Stool painful to pass

- ☐ Mucus in stool
- ☐ Use of laxatives

URINARY

- ☐ Frequent urination
- ☐ Weak urine stream
- ☐ Frequent bladder infections
- ☐ Frequent nighttime urination
- ☐ Dribbling urine after urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Pain or burning with urination
- ☐ Retain water/fluids

Urine color:

- ☐ Clear
- ☐ Straw
- ☐ Yellow

REPRODUCTIVE

Please complete sections that apply to your body.

- ☐ Decreased sexual desire
- ☐ Difficulty conceiving / fertility concerns
- ☐ Not currently sexually active
- ☐ Multiple sexual partners

TESTICULAR/PROSTATE HEALTH

- ☐ Penile burning/discharge
- ☐ Anal Intercourse
- ☐ Low sperm count
- ☐ Premature ejaculation
- ☐ Prostate issues
- ☐ Pain or coldness in genital area
- ☐ Swelling or lumps in testicles
- ☐ Difficulty achieving or maintaining an erection

Date of last prostate exam

- ☐ Have you had a PSA test?

Date? _____

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

Please complete sections that apply to your body.

PELVIC/REPRODUCTIVE HEALTH

- ☐ Vaginal Pain or sores
- ☐ Difficulty conceiving or fertility concerns
- ☐ Discharge from nipples
- ☐ Vaginal dryness or itching
- ☐ Ovarian cysts
- ☐ Breast lumps or cysts
- ☐ Vaginal discharge
- ☐ Pelvic infection
- ☐ Uterine fibroids
- ☐ Breast tenderness
- ☐ Vaginal infections
- ☐ Pain with intercourse
- ☐ Endometriosis
- ☐ Date of last mammogram _____
- ☐ Date of last PAP test and pelvic exam _____

MENSTRUATION/HORMONAL HEALTH

- ☐ Age of First Period _____
- ☐ How many days apart are your periods _____
- ☐ Absent periods (amenorrhea)
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Menstrual cramps or pain
- ☐ Spotting between periods
- ☐ Blood clots during menstruation
- ☐ Irregular periods
- ☐ Premenstrual bloating
- ☐ Are you currently or possibly pregnant?
- ☐ Number of pregnancies _____
- ☐ Number of live births _____
- ☐ Number of induced abortions _____
- ☐ Number of miscarriages _____

- ☐ C-sections?
- ☐ Complications with pregnancy, labor or delivery?
- ☐ Fertility treatment?
- ☐ Method of birth control:
- ☐ Current / Past: _____

MENOPAUSE

- ☐ Age when menstrual cycle ceased _____
- ☐ Currently menstruating?
- ☐ How often? _____
- ☐ Changes in cycle _____
- ☐ Hormone replacement therapy?
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Change in mood
- ☐ Change in sleep

ENDOCRINE/ IMMUNOLOGIC

- ☐ Neck enlargement

Intolerance to:

- ☐ Heat
- ☐ Cold
- ☐ Wind
- ☐ Dry Skin
- ☐ Fluid retention
- ☐ Depression
- ☐ Diabetes
- ☐ Abnormal weight gain
- ☐ Night sweats
- ☐ Unexplained fever/ chills
- ☐ Fatigue
- ☐ Abnormal weight loss
- ☐ Frequent low grade fever

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

NEUROLOGIC AND MUSCULOSKELETAL SYMPTOMS / CONDITIONS

- ☐ Nervousness
- ☐ Dizziness
- ☐ Numbness/Loss of sensation
- ☐ Tremors
- ☐ Seizures
- ☐ Convulsions
- ☐ Loss of coordination
- ☐ Paralysis
- ☐ Drowsiness
- ☐ Memory changes
- ☐ Fainting (syncope)
- ☐ Muscular weakness
- ☐ Nerve pain
- ☐ Arthritis
- ☐ Muscles spasms
- ☐ Swelling
- ☐ Stiffness
- ☐ Sciatica
- ☐ Disc injury
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Pain (describe)

_____

SLEEP

- ☐ Insomnia
- ☐ Difficulty staying asleep
- ☐ Wake up often at night
- ☐ Nightmares
- ☐ Wake up tired
- ☐ Difficulty falling asleep

WORK

Type of work or profession

_____

☐ Number of hours you work daily?

_____

I spend much of the day:

- ☐ Sitting
- ☐ Standing
- ☐ Heavy physical work
- ☐ On phone/computer

I find my work:

- ☐ Fulfilling
- ☐ Boring
- ☐ Challenging
- ☐ Exhausting
- ☐ Enjoyable
- ☐ Frustrating
- ☐ Stressful

TIME OF DAY/CLIMATIC FACTORS

Do you feel Better (B) or Worse (W):

- ☐ At home
- ☐ At Work
- ☐ Indoors
- ☐ Outdoors
- ☐ Cool/Cold/Snow
- ☐ In Wind
- ☐ Dry
- ☐ Hot

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

Stress/Emotions

Please check any feelings, qualities, or experiences you have had in the last twelve (12) months

☐ Frequent stress	☐ Suicidal thoughts	☐ Social or outgoing	☐ Easily offended
☐ Unusual fatigue	☐ Content	☐ Emotionally fragile	☐ Daytime sleepiness
☐ Lonely/isolated	☐ Disturbing dreams	☐ Frustrated	☐ Worried about small things
☐ Mood swings	☐ Perfectionist	☐ Despair	☐ Forgetful
☐ Difficulty with decisions	☐ Change in residence	☐ Depression	☐ Grief/loss/sorrow
☐ Nervous/anxious	☐ Spiritual practices	☐ Angry outbursts	☐ Change in work/job
☐ Loss of well-being	☐ History of eating disorder	☐ Tendency to be critical of others	☐ Substance use concerns
☐ Overwhelmed	☐ Feeling shaky	☐ Fulfilled	☐ Irritable
☐ Listless/Lethargic	☐ Memory changes	☐ Joyful	☐ High achieving tendencies
☐ Withdrawn	☐ Unusual tension	☐ Very sensitive	☐ Introspective
☐ Pressured	☐ Frequent crying	☐ Death of loved one	☐ Feeling hostile
☐ Conflicted	☐ Disappointment	☐ Prefer to be alone	☐ Change in marital status
☐ Poor concentration	☐ Self-critical	☐ Unhappy	

If you are currently experiencing thoughts of self-harm or suicide, please let your provider know -we are here to support you

What are your main sources of stress right now?

Tracy Ng, L.Ac., DAOM
Doctor of Acupuncture and Oriental Medicine

tracy.ng@mac.com | 818.634.6256
www.tracyng.com

HEALTH AND MEDICAL HISTORY

CONFIDENTIAL

My ability to cope with stress is:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

I am under the care of:

☐ Psychotherapist ☐ Psychiatrist

I am taking medication for:

☐ Mood ☐ Sleep ☐ Pain

List the problems below that concern you most, in order of importance

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

In your opinion, what factors contribute most to your condition or loss of well being?

What do you feel will help to achieve your goals?

How long do you expect the process to take?

Is there anything else you would like us to know?

Thank you for taking the time to reflect and share your insights!