DAY ONE
HEALTH HISTORY QUESTIONNAIRE

SLEEP PATTERNS

1. **Do you have trouble falling asleep? ____yes ____no**
2. **Do you awaken in the middle of the night as a result of your problem(s)? ____yes ____no**
3. **Is your sleep restful (do you wake refreshed)? ____yes ____no**
4. **Do you wake earlier than you would normally? ____yes ____no**
5. **Average hours of sleep a night _____**

Number of chief complaints _____ number of boxes marked _____

Loss of Function over Time:

Physical trauma: _____

_____

Chemical trauma: _____

_____

Emotional trauma: _____

_____

1. Where do you consider your health to be, above or below 30% _____
2. Are you discouraged with your current health status? ____yes ____no
3. If you are NOT discouraged, what adjective best describes how you view your health? _____

4. How do your health problems affect your relationship(s)?
   Work? _____
   Family/Friends? _____

_____

5. What hobbies or activities would you resume if it weren't for your health issues? _____

   _____

6. Would you agree that your health seems to be having a negative affect on your life? ____yes ____no
7. How much younger would you feel if your health concerns could be erased away? _____

8. If your health problems aren't resolved, and they have been going on for ____ months/years, what will be the result if they continue for another ____months/years. _____

_____

_____

9. Describe for me what a day of optimal health would look like for you: _____

_____

_____

10. On a scale of 1-10, with ten being the highest, how committed are you in wanting to rid yourself of these problems and feeling great? _____

If below 8, what is the reservation? _____

_____

11. What are 5 health goals that you would like to accomplish in the next 4-5 months?

1)

2)

3)

4)

5)

12. Assuming that we could help you with your condition, is there anything that would prevent you from following through with the treatment plan? ____yes ____no

13. Are there any other barriers to your commitment, e.g., time, transportation, other? Please specify:

_____

_____

_____

L.Ac's Signature: _____ **TX: ____ (____ of ____)**