



Marcy White M.Ac. Lic.Ac. 667 Boylston Street Boston, MA 02116 (617) 281-0797

HEALTH HISTORY QUESTIONNAIRE
(ALL ANSWERS ARE HELD CONFIDENTIAL)

Please complete the questionnaire as carefully as you can. All information that is provided will be kept strictly confidential and will not be released to any party without your specific written authorization. If you have any questions, please do not hesitate to ask. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the "Comments" section at the end. Thank You.

Today's date: ___ / ___ / ___

General

Name:			Work Phone: () -		Home Phone: () -	
Address:				City:		State:
Marital Status:	Age:	Date of Birth: / /		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Height:	Weight:
Email:			Insurance:		Occupation:	
Primary Care Physician:	Physician Phone: () -		Specialist Physician(s):		Specialist Phone: () -	
Emergency Contact:			Emergency Contact Phone: Day () - Evening () -			
Referred by:			Have you ever had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Main Complaint

Main Complaint (please provide details): _____

How long ago did this problem begin (be specific)?: _____

Have you received a diagnosis for this problem?: _____

If diagnosed, by whom?: _____

What kinds of treatment have you tried: _____

With whom? _____ What were the results: _____

Any other conditions you would like treated?: _____

Current Medications

Vitamins/Mineral/Herbal Supplements or over the counter medication within the last **3 months**:

1: _____ Dose: _____ Reason for taking: _____
2: _____ Dose: _____ Reason for taking: _____
3: _____ Dose: _____ Reason for taking: _____
4: _____ Dose: _____ Reason for taking: _____
Other: _____

Physician prescribed medicine within the last **3 months**:

1: _____ Dose: _____ Reason for taking: _____
2: _____ Dose: _____ Reason for taking: _____
3: _____ Dose: _____ Reason for taking: _____
4: _____ Dose: _____ Reason for taking: _____
5: _____ Dose: _____ Reason for taking: _____
Other: _____

Past Medical History

(Please include dates)

<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Food Poisoning _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Chronic Fatigue _____	<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> TB _____
<input type="checkbox"/> Emphysema _____	<input type="checkbox"/> H.I.V. _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Mononucleosis _____	<input type="checkbox"/> Venereal Disease _____
<input type="checkbox"/> Fibromyalgia _____	<input type="checkbox"/> Nervous Breakdown _____	

Surgeries (type and date): _____

Significant Trauma (auto accidents, falls, head injuries, etc.) _____

Allergies (drugs, chemicals, foods) _____

Social Health History

Do you smoke? Yes No If yes, how many per day? _____ At what age did you start? _____
Do you drink coffee? Yes No Cups per day? _____ Reg or Decaf? Soda? Yes No Per day? _____
Do you drink alcohol? Yes No How often? _____ What do you drink? _____
Do you use recreational drugs? Yes No What type? _____ How often? _____
Do you have a regular exercise program? Yes No If yes, please describe _____
Have you ever been on a restricted diet? Yes No If yes, please describe _____

Family History

- | | | |
|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | |

Please describe your average daily diet:

Morning	snack	Afternoon	snack	Evening	snack

How much water do you drink per day? _____

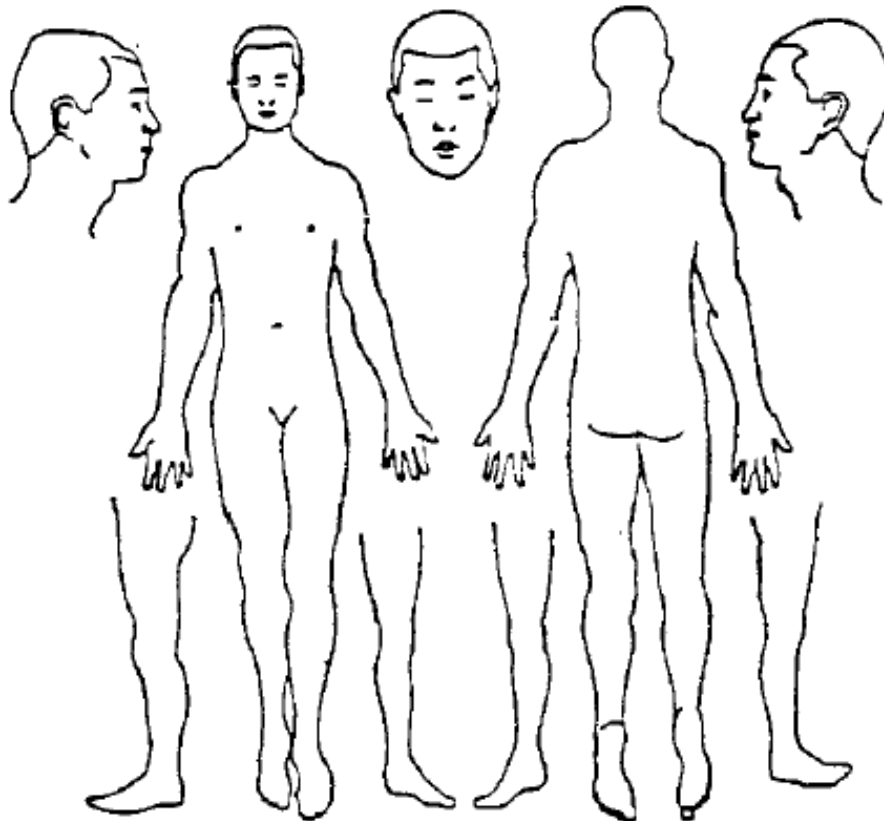
Please check all of the symptoms you have experienced in the last 3 months:

O = OCCASIONAL, F = FREQUENT C = CONSTANT

Type of Pain (please indicate on diagram below)

- | | | | |
|--|---|---|--|
| O F C | O F C | O F C | O F C |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pins & needles | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sharp stabbing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dull, achey |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deep | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Throbbing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramping | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Electricity |

Please mark all areas below with an "X" where you experience, pain, aching, burning, throbbing, etc.



General

O F C

- General body aches
- Fevers
- Sweats easily
- Bleed or bruise easily
- Peculiar tastes or smells
- Sudden energy drop (what time of day?)_____

O F C

- Poor sleeping
- Reduced sexual energy
- Change in appetite
- Strong thirst (hot or cold drinks)
- Fatigue

O F C

- Night sweats
- Cravings
- Catch Colds
- Chills
- Weight gain
- Weight loss

Please check all of the symptoms you have experienced in the last 3 months:

O = OCCASIONAL,

F = FREQUENT

C = CONSTANT

Skin & Hair

O F C

- Rashes
- Eczema
- Dry skin

O F C

- Ulcerations
- Pimples

O F C

- Hives
- Dandruff

O F C

- Itchy skin
- Loss of hair

Change in hair or skin texture:_____

Any other hair or skin problems?_____

Head, Eyes, Ears, Nose & Throat

O F C

- Dizziness
- Jaw clicks
- Facial pain
- Earaches
- Ringing in ears
- Teeth problems
- Grinding teeth
- Blurry vision
- Eye pain

O F C

- Sinus congestion
- Eye strain
- Spots in front of eyes
- Dry Eyes
- Excessive tearing
- Sore throats
- Sores on lips or tongue
- Nose bleeds
- Loss of smell

O F C

- Hoarseness
- Hearing loss
- Night blindness
- Poor Vision
- Cataracts
- Glasses
- Color blindness
- Concussions_____ (date)

Do you get Headaches/Migraines? Yes No What may be causing them?_____

What part of the head is affected? Top Temples Back Behind the Eyes Other:_____

Any other head or neck problems?_____

Cardiovascular

O F C

- Chest pain
- Irregular heartbeat
- Cold hands and feet
- Difficulty in breathing

O F C

- Fainting
- Swelling of hands
- Phlebitis
- Swelling of feet/legs

O F C

- High blood pressure
- Low blood pressure
- Bruise easily
- Blood clots

Any other heart or blood circulation problems?_____

Respiratory

O F C

- Cough
- Bronchitis
- Difficulty in breathing when lying down

O F C

- Coughing blood
- Pneumonia

O F C

- Asthma/Wheezing
- Pain with a deep breath

Any phlegm production Yes No What color and consistency?_____

Any other lung problems?_____

Gastrointestinal

O F C

- Nausea
- Vomiting
- Excessive hunger
- Black stools
- Abdominal pain

O F C

- Belching
- Gas
- Blood in stools
- Rectal pain
- Laxative use

O F C

- Diarrhea
- Constipation
- Indigestion
- Hemorrhoids
- Poor appetite

O F C

- Colitis
- Heart burn
- Bad breath

Bloating. Does this bloating come immediately after meals or hours after? _____

How often do you have a bowel movement? _____

Any other problems with your stomach or intestines? _____

Please check all of the symptoms you have experienced in the last 3 months:

O = OCCASIONAL,

F = FREQUENT

C = CONSTANT

Genito-Urinary

O F C

- Pain upon urination
- Frequent urination
- Impotence
- Dribbling

How many times per day do you urinate? _____

O F C

- Blood in urine
- Unable to hold urine
- Decrease in urine flow
- Urgency to urinate

Do you wake up to urinate? How often? _____

O F C

- Kidney stones
- Lack of bladder control
- Sores on genitals

Any particular color to your urine (pale, dark, cloudy)? _____

Any other problems with your genital or urinary systems? _____

Musculoskeletal

O F C

- Neck pain
- Stiff neck
- Neck "pops"
- Hand/wrist pain
- Loss of grip strength
- Pins & needles in fingers

Any other muscle, joint or bone problems? _____

O F C

- Sore finger joints
- Shoulder pain
- Can't raise arm over head
- Burning mid back pain
- Spinal curvature
- Muscle weakness (where?) _____

O F C

- Back pain
- Knee pain
- Knee "gives out"
- Foot/ankle pain
- Hip pain

Neuropsychological

O F C

- Seizures
- Areas of numbness
- Tremors
- Bad temper

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

O F C

- Lack of coordination
- Depression
- Easily susceptible to stress
- Insomnia

O F C

- Loss of balance
- Poor memory
- Anxiety

Reproductive and Gynecological

Age of 1st menses _____

Fertility issues: _____

Number of days period lasts _____

Changes in body/psyche prior to period: _____

Number of days between periods _____

Date of last period _____

# of pregnancies _____	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Menstrual clots
# of live births _____	<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Unusual periods (Heavy / Light)
# of premature births _____	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Spotting or pain between periods
# of miscarriages _____	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Menopause: age _____, year _____
# of abortions _____	<input type="checkbox"/> Menstrual pain	Date of last pap _____ Results _____
Pain with menstruation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After period
Fatigue with menstruation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After period

Do you practice birth control? What type and for how long? _____

Is there any chance that you are pregnant now? _____

Do you have a pacemaker or use a heart monitor? _____

COMMENTS:

Please tell us of any other problems you would like to discuss.
