Health History

Please take time to fill out this questionnaire carefully. The information you provide helps me to determine an accurate TCM diagnosis. All answers are confidential. Please let me know if you have questions.

Name: ____ Date: ____________
First MI Last

Address: ____

City:_____________________________________State:_______Zip:______________

Home Phone: ____________________ Cell Phone:_____________________________

Email:_________________________________ DOB:____________Age:______________

Height: ____________ Weight: ___________

Occupation: __________________________ Employer:_________________________

Marital Status: __________________ Spouse's Name:_________________________

Who may we thank for referring you? ____________________________________

Physician: ______________________________________ Phone:________________

Address: _________________________________ City___________State:_____ Zip:_____

In Emergency Notify:______________________________ Phone:__________________

CHIEF COMPLAINT: Please describe your concern in as much detail as possible (symptoms, duration etc.).

____

____

____

____

____

Have you received a diagnosis for this condition? ______________By whom? ______________

Please list any additional physicians, healthcare practitioners, or treatments you have received for this condition:

Provider Name Address Phone

Treatment Received Dates of Care

Provider Name Address Phone

Treatment Received Dates of Care

CURRENT MEDICATIONS

Please list all prescription medications, over-the-counter medication, supplements, herbs or homeopathic remedies you have taken in the last 3 months. Please attach an additional page if necessary.

NAME	DATE BEGAN	DOSAGE	REASON FOR TAKING

SURGERIES & HOSPITALIZATIONS

Please indicate the reason and date for any surgeries or hospitalizations:

SIGNIFICANT TRAUMA (Physical or Emotional)

ALLERGIES (Chemical, Environmental, Food, Drug etc.)

MEDICAL HISTORY: Please complete the following chart for yourself and for each family member by placing an X in the appropriate box. Use the blank columns for additional family members.

Health History	SELF	MOTHER	FATHER	BROTHER	SISTER		
Age							
Allergies							
Anemia							
Arthritis (OA or RA)							
Asthma							
Cancer							
Chemical Dependency							
Chronic Fatigue							
Chronic Pain Condition							
Diabetes							
Emphysema							
Fibromyalgia							
Food Allergies/Intolerance							
Gastrointestinal disorder							
Heart Disease							
Hepatitis							
High/Low Blood Pressure							
Infertility							
Kidney Disease							
Liver/Gall Bladder Disease							
Lyme Disease							
Mental Illness							
Multiple Sclerosis							
Osteoporosis							
Raynauds							
Seizures							
Stroke							
Thyroid Disorder							

REVIEW OF SYSTEMS: Please indicate all symptoms you feel are significant or which you have experienced in the last 6 months.

HEAD, EYES, EARS, NOSE and THROAT

- ☐ Headaches/Migraines
- ☐ Grinding Teeth
- ☐ Jaw clicks/Pain
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Dry eyes
- ☐ Spots in front of eyes
- ☐ Night blindness
- ☐ Cataracts
- ☐ Contacts/Glasses
- ☐ Glaucoma
- ☐ Facial pain
- ☐ Ear ringing
- ☐ Earaches
- ☐ Hearing Loss
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Post nasal drip
- ☐ Difficulty swallowing
- ☐ Sores on lips/tongue

Have you experienced any other head, eyes, ears, nose or throat problems? (circle) YES NO

RESPIRATORY

☐ Cough
☐ Frequent Colds/Flu
☐ Tight sensation in chest
☐ Allergies
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Shortness of Breath/Wheezing
☐ Production of Phlegm…color? ________________________

Have you experienced any other respiratory problems? (circle one) YES NO

SKIN & HAIR

☐ Rashes
☐ Ulcerations
☐ Eczema
☐ Psoriasis
☐ Dry skin
☐ Acne
☐ Warts
☐ Loss of hair
☐ Fungal infection
☐ Itching
☐ Moles
☐ Hives/allergic dermatitis
☐ Face flushing
☐ Change in skin/hair texture
☐ Rosacea

Have you experienced any other skin problems? (circle one) YES NO

CARDIOVASCULAR

☐ Bruise easily
☐ Chest Pain/Pressure
☐ Cold Hands/Feet
☐ Blood Clots
☐ Dizziness
☐ High blood pressure
☐ Low blood pressure
☐ Fainting
☐ Murmur
☐ Pacemaker
☐ Palpitations
☐ Swelling of hands/feet
☐ Varicose/spider veins
☐ Spontaneous sweating

Have you experienced any other heart/circulation problems? (circle one) YES NO

GASTROINTESTINAL

☐ Nausea
☐ Vomiting
☐ Bloating
☐ Gas
☐ Diarrhea/loose stool
☐ Abdominal pain/cramps
☐ Constipation
☐ Blood in stool
☐ Mucus in stool
☐ Decreased/Poor appetite
☐ Excessive appetite
☐ Eating disorder
☐ Hemorrhoids
☐ Chronic laxatives
☐ Ulcer
☐ Belching
☐ Significant thirst
☐ Rectal pain
☐ IBS
☐ Crohn's disease
☐ Acid reflux/GERD

Have you experienced any other digestive problems? (circle one) YES NO

GENITO-URINARY

☐ Blood in urine
☐ Burning urination
☐ Cloudy urine
☐ Infections
☐ Decreased urination (<5x/day)
☐ Frequent urination (>10x/day)
☐ Dribbling after urination
☐ Urination at night…Time? ________How often_____
☐ Kidney stones
☐ Painful urination
☐ Urinary incontinence

Have you experienced any other genitourinary problems? (circle one) YES NO

WOMEN'S HEALTH

□ Absence of period	□ Infertility	□ Vaginal infections	□ Uterine Fibroids
□ Hot flashes/nightsweats	□ Irregular menstruation	□ Vaginal dryness	□ Endometriosis
□ Decreased sex drive	□ Scant/light bleeding	□ Vaginal itching	□Swelling/Pain of breasts
□ Painful intercourse	□ Menstrual Clots	□ Vaginal pain	
□ Heavy bleeding	□ Menstrual Pain	□ Ovarian Cysts	
□ Bleeding between periods		□ Polycystic Ovarian Disease	

Have you experienced any other gynecologic problems? (circle one) YES NO

____

____

Please indicate the correct number.

Age of first menses__________________ Number of days in between cycles__________

First day of last period______________ Age of Menopause_________________________

Number of days you bleed__________ Date of last PAP/Pelvic exam_______________

Describe your average monthly cycle:

____

____

Please list number of:

Pregnancies_____________ Ectopic pregnancies____________ C-Sections________________________

Births___________________ Elective abortions_______________ Premature Births_________________

Children_________________ Miscarriages_____________________

Are you currently pregnant? (circle one) YES (#weeks______) NO

Are you currently trying to conceive? (circle one) YES NO

Are you currently nursing? (circle one) YES NO

Are you sexually active? (circle one) YES NO

Do you practice birth control? YES NO

What type?__________________How long?________________________

MENS HEALTH

□ Decreased sex drive	□ Genital pain	□ Infertility
□ Genital itching	□ Impotence	□ Prostate enlargement

Have you experienced any other genito-urinary problems? (circle one) YES NO

MUSCULOSKELETAL

- ☐ Ankle/Foot pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Back Pain Low____Middle___Upper_____
- ☐ Loss of sensation
- ☐ Muscle spasm
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Numbness/tingling
- ☐ Sciatica
- ☐ Tendonitis
- ☐ Sprain/Strain
- ☐ Swelling
- ☐ Pelvic pain

What is your chief musculo-skeletal complaint and when did this condition begin?

____

How frequent and for how long do you experience pain?___________________________________

What is the intensity of the pain on a scale of 1-10? 1 2 3 4 5 6 7 8 9 10

What is the quality of your pain? Place an X in any box that applies.

- ☐ Achy
- ☐ Burning
- ☐ Dull
- ☐ Electric
- ☐ Loss of Sensation
- ☐ Throbbing/Pulsing
- ☐ Heavy
- ☐ Sharp
- ☐ Stabbing

Does your pain radiate or travel to any other area of your body? ____________________________

Have you had recent X-rays, MRIs, CT scans or other tests performed? YES NO

NEUROLOGICAL

- ☐ Change in gait
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Concussion
- ☐ Loss of sensation
- ☐ Numbness
- ☐ Seizures
- ☐ Slow or slurred speech
- ☐ Tremors
- ☐ Vertigo/Dizziness

Have you experienced any other neurological problem? (circle one) YES NO

MENTAL HEALTH

- ☐ Anger
- ☐ Anxiety
- ☐ Crying
- ☐ Depression
- ☐ Fear
- ☐ Grief
- ☐ Irritability
- ☐ Lethargy
- ☐ Poor memory
- ☐ Mood swings
- ☐ Nervousness
- ☐ Poor Concentration
- ☐ Restlessness
- ☐ Easily susceptible stress
- ☐ ADD/ADHD

On a scale of 1-10, please rate your stress level: 1 2 3 4 5 6 7 8 9 10

What are the major stress factors in your life? ____

Please rate your current emotional health: (circle one) excellent good fair poor

Are you currently in therapy, counseling or involved in a support group? YES NO
Have you ever been treated for emotional problems? YES NO
Have you ever considered or attempted suicide? YES NO

SLEEP

Typically, how many hours per night do you sleep? ________Do you feel rested when you wake up? _______

Do you have insomnia? Y/N If yes, how long does it take to fall asleep? ______________________

Are you up throughout the night? Y/N How many times? ___________ For how long? ______________

Any other difficulties with sleep (e.g. Hot/cold, active dreams, nightmares etc.)?
____

ENERGY

How would you describe your energy? (circle one) excellent good average tired exhausted

Have you experienced any significant change in your energy level? YES NO

NUTRITION

Please describe your typical diet in the chart below. Include beverages (water, soda, coffee etc.)

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK

Please indicate any of the following substances, which apply to you now or in the past.

Alcohol	Yes	No	_____amount per day/week	____age began_____age quit
Crack/cocaine	Yes	No	_____use per day/week	____age began_____age quit
Heroin	Yes	No	_____use per day/week	____age began_____age quit
Marijuana	Yes	No	_____use per day/week	____age began_____age quit
Tobacco (cigarettes)	Yes	No	_____cigarettes per day/week	____age began_____age quit
Other recreational drugs	Yes	No	_____use per day/week	____age began_____age quit

Have you ever been treated for substance abuse? YES NO

EXERCISE

What type of exercise do you do? ______________________________

How frequent and for how long? ______________________________

Are you training for any event or do you have specific exercise goals? ______________________________

GOALS

What are your current health goals? ______________________________

What potential obstacles do you have in achieving these goals?______________________________

ADDITIONAL COMMENTS

Please address any additional concerns or conditions. Please include anything else about yourself that you would like me to know. You may also include any concerns or questions that you have specifically about acupuncture.

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____
____
____
____

I have carefully read the above information and certify it to be true.

Signature of client or legal guardian: ______________________________Date: ______________

Practitioner signature: ______________________________Date: ______________
Erin Walker, Licensed Acupuncturist
Boston Integrated Health, LLC