AcuPUNKture: Your *Alternative* Place for Healing

Health History Questionnaire

Name: _____
Date of Birth: _____ Age: _____
Address: _____
Email: _____Phone #: _____
Emergency Contact Name and #:_____
Relationship to you: _____
Occupation: _____
Children (ages): _____
Gender: _____ Gender Identity: _____
Sexual orientation: _____
Preferred pronoun(s): _____
Relationship Status: _____
How did you hear about us? _____

Main Complaints (MC):

MC1:
When did it start:
Any Western diagnosis?

MC2:
When did it start:
Any Western Diagnosis?

MC3:
When did it start:
Any Western Diagnosis?

Medications/Vitamins/Herbs:

Name:	Reason for taking:	Date started medication:
-		
-		
-		
-		
-		

Significant Trauma/Surgery (accidents/ falls etc.):

_____
_____
_____

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Medical History: □ Asthma □ Allergies □ Cancer □ Thyroid conditions □ Heart Disease □ Stroke □ High blood pressure □ Low blood pressure □ Rheumatic fever □ Diabetes: type 1 or 2 □ Other: _____

Family Medical History: □ Asthma □ Allergies □ Cancer □ Thyroid conditions □ Heart Disease □ Stroke □ High blood pressure □ Low blood pressure □ Rheumatic fever □ Diabetes: type 1, 2 □ Other: _____

Allergies (seasonal/metals/foods/meds): _____

Any areas of life you find stressful? _____

Exercise habits (if any): _____

Lifestyle habits: Recreational Drugs: _____ Alcohol _____ x/week
Tobacco _____x/week Caffeine: _____ cup/day Water _____ glasses/day

Digestion:

□ gas	□ bloating/ edema	□ acid reflux/ GERD
□ fatigue after meals	□ belching	□ nausea
□ vomiting	□ eating disorders	□ binge eating
□ IBS/ Crohn's disease	□ diarrhea	□ constipation
□ excessive appetite	□ poor appetite	□ black stools
□ blood in stools	□ bypass surgery	□ slow digestion
□ abdominal cramps	□ indigestion	□ rectal pain
□ abdominal pain/cramping	□ bad breath	□ bleeding gums
□ hemorrhoids	□ slow digestion	□ chronic laxative use
□ food stagnation	□ loose stools, more than 2/day	□ any other Stomach/intestinal issues: _____

Diet: □ vegan □ vegetarian □ macrobiotic □ medical related □ other _____
Morning: _____
Afternoon: _____
Evening: _____
Snacks: _____

Sleep/Energy:

□ poor sleep quality	□ tossing and turning	□ vivid Dreams	□ dips in energy
□ insomnia	□ difficulty falling asleep/waking	□ difficulty staying asleep	□ low energy
□ waking to urinate	□ waking at specific time every night: _____ A.M.	□ night terrors	□ other: _____

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Mental-emotional/Neurological:

□ dizziness	□ vertigo	□ poor memory
□ concussion	□ depression	□ manic/depression
□ bad temper	□ nervousness	□ ADD/ADHD
□ seizures/ tics	□ poor coordination	□ areas of numbness

Does any emotion resonate most often with you: □ anger □ joy □ worry □ sadness □ fear
Have you ever been treated for emotional problems: □ yes □ no □ no comment
Have you ever considered or attempted suicide: □ yes □ no □ no comment
Any other neurological or psychological problems/concerns: _____

Head, Ear, Eyes, Nose, Throat (HEENT):

□ migraines	□ nose bleeds	□ sinus congestion
□ excessive ear wax	□ poor hearing	□ recurrent Sore throats
□ earaches	□ ringing in ears	□ grinding teeth
□ clenching jaw	□ clicking jaw	□ TMJ
□ facial pain	□ teeth issues	□ sores on lips/tongue
□ eye strain	□ eye pain	□ red/itchy eyes
□ poor vision	□ night blindness	□ cataracts

□ Headaches: where and when: _____

□ Any other HEENT concerns: _____

Skin/Hair/Nails:

□ hair loss	□ hair thinning	□ new hair growth on body
□ rashes	□ eczema	□ pimples/acne
□ psoriasis	□ itching	□ hives
□ dermatitis	□ recent moles	□ dry skin
□ oily skin	□ dry hair	□ oily hair
□ Brittle nails	□ dark nails	□ fungus

Any other hair/skin/nail concerns: _____

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Urinary:

Color: □ clear □ light yellow □ dark yellow □ other : _____

□ Painful	□ Burning	□ Urgency
□ Cloudy	□ Blood	□ Dribbling
□ Frequent Urination	□ Difficulty stopping/starting	□ Incontinence
□ Incomplete sensation	□ Kidney stones	□ Hx. Of UTIs

Respiratory/ Cardiovascular:

□ Asthma	□ Shortness of breath	□ Difficulty taking inhale
□ Cough	□ Tight chest	□ Difficulty exhaling
□ Phlegm color_____	□ Coughing blood	□ Bronchitis
□ Pneumonia	□ Pain with deep breathe	□ Difficulty breathing when lying down
□ Palpitations	□ Irregular heartbeat	□ Chest Pain
□ Cold hands and feet	□ Swelling of hands/feet	□ varicose/spider veins
□ blood clots	□ fainting	□ phlebitis

Any other respiratory or cardiovascular concerns: _____

MusculoSkeletal:

□ Neck pain	□ Rotator cuff	□ Knee pain	□ Foot/ankle pain
□ Muscle pain	□ Muscle spasm	□ Muscle weakness	□ Shoulder pain
□ Hip pain	□ Sciatica	□ Bursitis	□ Hand/wrist pain
□ Carpal tunnel	□ Sprains/strains	□ Tendonitis	□ Other _____

□ Back pain: Low_____ Middle_____ Upper_____
□ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

Western diagnosis (if any) and year diagnosed: _____

Sexual Health:

Sexually Active? □ Yes □ No □ Prefer not to comment
Birth Control/Disease prevention Methods? _____
STDs: _____
Hormone replacement therapies, if so what? _____
Genital Reconstructive Surgery? if so when? _____

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Check all that apply:

□ Decreased sex drive	□ Erectile dysfunction	□ Premature ejaculation
□ Discharge	□ Prostate disease	□ Testicular masses
□ Testicular pain	□ Vasectomy	□ Hysterectomy
□ Sex change	□ Hernia	□ Fibroids
□ Ovarian cysts	□ Jock itch	□ Vaginal dryness
□ Yeast infections	□ UTIs	□ Endometriosis
□ Night sweats ____nights/wk	□ Hot flashes _____x/day	□ Osteoporosis
□ breast lumps	□ Polycystic Ovary Disease	□ Fibrocystic Breast tissue

Any other sexual concerns: _____

Fill in/Circle if applicable:

First Period: _____ years old Last Menstrual Period (date): _____

Duration of menses: _____ days

Pregnancies:

Births:

Flow: Heavy, Light, Painful, Irregular, PMS, breast tenderness, cramps, clots, Spotting, fatigue with menses

COMMENTS: ***Please tell us briefly any other problems you would like to discuss or concerns you may have regarding your treatment.***

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Consent To Treat:

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist of AcuPUNKture. I understand that acupuncturists practicing in the State of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner(s).

ACUPUNCTURE AND TREATMENT MODALITIES: I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion or the use of a conventional heat lamp, cupping, gua-sha, electoral stimulation, Tui-Na (Chinese massage), essential oils, press balls, press tacks and nutrition counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua-sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses single use sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion, heat lamp use and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The essential oils (which are from plant, animal and mineral sources) that have been recommended and used are traditional considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some essential oils may be inappropriate during pregnancy. Some possible side effects of using essential oils are acute skin irritation, redness, heat, hives, tingling, itching or skin photosensitivity. I understand that these essential oils are for topical use only and should not be ingested.
I do not expect the licensed acupuncturist(s) to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the licensed acupuncturist(s) to exercise judgment during the course of treatment which the licensed acupuncturist(s) thinks at the time, based upon the facts then known is in my best interest. I understand the results are not guaranteed.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY: I understand the licensed acupuncturist(s) and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I have been presented with a copy of The Notice of Privacy Policies for the office of AcuPUNKture and I understand how this clinic may use or disclose my health information.

LATE CANCELLATION/NO SHOW POLICY: A minimum of 24 hours is required to reschedule or cancel an appointment. Unless otherwise agreed upon in advance or in the case of an emergency or inclement weather, *the full price of a treatment or one session from a treatment package will be deducted for each missed appointment.* There is a $35 fee for returned checks.

PREPAID SESSION PACKAGE: If you choose to purchase a session package for follow-up treatments, please note that they are non-refundable/non-transferrable no matter what the circumstances. They never expire and can be shared with friends and family. They are designed to be used on a regular basis to save you money and allow you to feel at your best.

By signing below, I show that I have carefully read and understand, or have had read to me, the above consent to treatment and policies, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent to treat form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: _____ Date: _____
(If under 18 years of age a parent or legal guardian must sign.)
Printed Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Email: _____