Stone Acupuncture
2016 Ocean Street Marshfield, MA 02050
78-223-0130

Health History Questionnaire

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____ Age: _____ Gender: M/F Marital Status:_____

Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

email:_____ Please indicate best way to reach you:_____

Family physician:_____ Emergency contact/phone:_____

Occupation:_____ Referred by:_____

Have you been treated with Acupuncture before? Y/N

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All of your answers will be held completely confidential. Thank you.

MAIN COMPLAINT

Main problem(s) you would like us to help you with:_____

_____

_____

How long ago did this problem begin?_____

Does this problem interfere with your daily activites?_____

Have you been given a Western Medical diagnosis?_____

What other forms of treatment have you tried?_____

Secondary issues you would like to work on:_____

_____

GENERAL

Current Medications/Vitamins/Supplements:_____

Allergies:_____ Surgeries:_____

Height:_____ Weight:_____ Do you smoke? Y/N If yes, how much?_____

How much caffeine per day?_____How much water/day?_____Alcohol?_____

Do you typically eat at least 3 meals day? Y/N If no, how many?_____

Exercise routine:_____

MEDICAL HISTORY

Personal Medical History – Past or Present

☐ Cancer	☐ Diabetes	☐ Seizures
☐ Stroke	☐ Heart Disease	☐ Thyroid Disease
☐ Hepatitis	☐ High Blood Pressure	☐ Other_____

Family Medical History – Please check any condition that applies to your immediate family.

☐ Cancer	☐ Diabetes	☐ Seizures
☐ Stroke	☐ Heart Disease	☐ High Blood Pressure
☐ Allergies	☐ Asthma	☐ Other_____

General – Please check if you have had any of these items listed below within the last 3 months.

☐ Poor Sleeping	☐ Night Sweats	☐ Fatigue
☐ Sweats Easily	☐ Weight Loss	☐ Cravings
☐ Change in Appetite	☐ Weight Gain	☐ Fevers
☐ Sudden Energy Drop	☐ Bleed/Bruise Easily	☐ Poor Appetite
☐ Peculiar Tastes or Smells	☐ Dental Problems	☐ Strong Thirst (hot or cold)

Skin and Hair

☐ Rashes	☐ Itching	☐ Hives
☐ Dandruff	☐ Eczema	☐ Acne
☐ Recent Moles	☐ Loss of Hair	☐ Change in skin/hair texture
☐ Warts	☐ Ulcerations	☐ Skin Discoloration

Head, Eyes, Ears, Nose and Throat

☐ Dizziness	☐ Migraines	☐ Eye Pain
☐ Eye Strain	☐ Poor Vision	☐ Cataracts
☐ Blurry Vision	☐ Night Blindness	☐ Color Blindness
☐ Spots in Front of Eyes	☐ Glasses	☐ Ringing in the Ears
☐ Poor Hearing	☐ Grinding Teeth	☐ Facial Pain
☐ Nose Bleeds	☐ Sinus Problems	☐ Earaches
☐ Headaches	☐ Jaw Clicks	☐ Sores on Lips/Tongue
☐ Dental Problems	☐ Recurrent Sore Throats	☐ Difficulty Swallowing

Cardiovascular

☐ Low Blood Pressure	☐ Chest Pain or Pressure	☐ Irregular Heart Beat
☐ Cold Hands/Feet	☐ Palpitations	☐ Varicose/Spider Veins
☐ Swelling of Hands/Feet	☐ Shortness of Breath	☐ Spontaneous Sweating
☐ Blood Clots	☐ Fainting	☐ Phlebitis

Respiratory

☐ Cough/Wheezing	☐ Coughing Blood	☐ Bronchitis
☐ Pneumonia	☐ Asthma	☐ Difficult Breathing
☐ Pain with Deep Inhalation	☐ Production of Phlegm...if so what color?_____	

Gastrointestinal

☐ Nausea	☐ Vomiting	☐ Constipation
☐ Diarrhea	☐ Gas	☐ Belching
☐ Indigestion	☐ Blood in Stools	☐ Black Stools
☐ Rectal Pain	☐ Hemorrhoids	☐ Chronic Laxative Use
☐ Bad Breath	☐ Bloating/Edema	☐ Acid Reflux
☐ Hernia	☐ IBS/Crohn's Disease	☐ Abdominal Pain/Cramps

Genito-Urinary

☐ Pain upon Urination	☐ Urgency to Urinate	☐ Decrease in Flow
☐ Frequent Urination	☐ Blood in Urine	☐ Sore on Genitals
☐ Kidney Stones	☐ Unable to Hold Urine	☐ Impotence
☐ Decreased Libido	☐ Urinary Tract Infection	☐ Dribbling after Urination
☐ Herpes	☐ Prostatitis	☐ Night Urination

Gynecological/Reproductive

☐ Painful Periods	☐ Vaginal Discharge	☐ Age of first Menses_____
☐ Irregular Menstruation	☐ Ovarian Cysts	☐ Date of last Menses_____
☐ Endometriosis	☐ Infertility	☐ Date of last PAP_____
☐ Vaginal Sores	☐ Vaginal Dryness	☐ Number of Pregnancies_____
☐ Polycystic Ovarian Disease	☐ Uterine Fibroids	☐ Number of live Births_____
☐ Fibrocystic Breast Tissue	☐ Number of Abortions____	☐ Number of Miscarriages_____

Musculoskeletal

☐ Back Pain	☐ Knee Pain	☐ Neck Pain
☐ Hip Pain	☐ Shoulder Pain	☐ Sciatica
☐ Bursitis	☐ Sprains/Strains	☐ Muscle Pain
☐ Hand/Wrist Pain	☐ Foot/Ankle Pain	☐ Tendonitis
☐ Carpal Tunnel	☐ Rotator Cuff	☐ Muscle Weakness

Neurological

☐ Seizures	☐ Vertigo/Dizziness	☐ Lack of Coordination
☐ Loss of Balance	☐ Areas of Numbness	☐ Poor Memory
☐ ADD/ADHD	☐ Manic Depression	☐ Concussion

Emotional/Psycological

☐ Anxiety/Panic Attacks	☐ Depression	☐ Bad Temper/Irritability
☐ Nervousness	☐ Easily Susceptible to Stress	

Have you even been treated for emotional problems?_____

Have you ever considered or attempted suicide?_____

Have you ever been treated for substance abuse?_____

Have you ever had any physical or emotional traumas?_____

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

_____

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