HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be kept absolutely confidential.* If you have any questions, please do not hesitate to ask. If there is anything you wish to bring to our attention, which is not asked on this form, please note it in the "Comments" section. Thank you.

Date: ____________________

Name: ____________________ Date of Birth: __________ Height: ________ Weight: _____

Marital Status: ____________________ Email Address: ____________________________

Home Phone: ______________ Work: ______________ Cell: ____________________

Street: ______________ City: ____________________ State: _____ Zip: __________

Emergency Contact (Name and Number): ____

Family Physician: ____________________ Referred By: ________________________

Have you been treated by acupuncture or Oriental medicine before? ☐ Yes ☐ No

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

How long ago did this problem begin? Please be specific: __________________________

To what extent does this problem interfere with your daily activities, such as work, sleep, and sex?

____

Have you been given a diagnosis for this problem? If so, what? ______________________

What kinds of treatment have you tried? ______________________________________

PAST MEDICAL HISTORY (Please include dates)

Significant Illnesses *(please circle all applicable):*

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease

Rheumatic Fever Thyroid Disease Seizures Venereal Disease Other

Surgeries: ____

Significant trauma (auto accidents, falls, etc): ______________________________

Allergies: ____

Are there other medical implants we should know about? (i.e. A pacemaker, a shunt, etc): ____

FAMILY MEDICAL HISTORY:

Diabetes Cancer High Blood Pressure Heart Disease Stroke

Seizures Asthma Allergies Other:

Medicines take within the last two months (vitamins, drugs, herbs, etc): ____________

Occupational stress (chemical, physical, psychological, etc): ____________

Do you have a regular exercise program? If yes, please describe: ____________

Have you ever been on a restricted diet? If yes, what kind? ____________

Please describe your daily diet:

Morning:	Afternoon:	Evening:

How much water do you drink per day? ____________

Do you smoke? If yes, how much? ____________

How much caffeinated coffee, tea, or cola do you drink per week? ____________

Please describe any use of drugs for non-medical purposes? ____________

Indicate any painful or distressed areas: ____________

____

____

DAILY PAIN SUMMARY

Did you have pain today? ____ NO ____ YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain? ____NO ____YES: What activities? ____________

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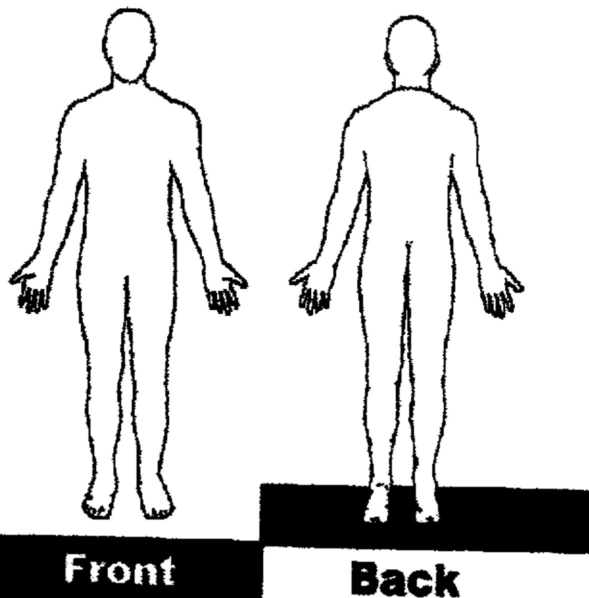
How many times did this happen today? (Please Circle)

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: What activities? __________



Put an "X" on the body diagram to show each place you've had pain today.

What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?

____NO ____YES (Check any that you used.)

____Non-prescription drugs (e.g., acetaminophen, ibuprofen)

____Herbal remedies

____Hot or cold packs

____Exercise

____Changing position (such as lying down or elevating your legs)

____Physical therapy

____Massage

____Acupuncture

____Rest

____Psychological counseling

____Talk to trusted friend, family, clergy

____Prayer, meditation, guided imagery

____Relaxation technique (hypnosis, biofeedback)

____Creative technique (art or music therapy)

____Other (describe): ____

Check any of these common side effects that you've noticed after taking your pain medicine:

____Drowsiness, sleepiness

____Nausea, vomiting, upset stomach

____Constipation

____Lack of appetite

____Other (describe): ____

Did you skip any of your schedule pain medicines today? ____NO ____YES: Why? ____________

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO (Explain what makes you not satisfied. Please use the comments section at the end of the Health History Questionnaire).

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

Please check if you have had (in the last three months):

☐ Poor Sleeping	☐ Night Sweats	☐ Weight gain
☐ Fevers	☐ Sweat easily	☐ Chills
☐ Craving	☐ Bleed or bruise easily	☐ Weight loss
☐ Change in appetite	☐ Peculiar tastes or smells	☐ Strong thirst

☐ Sudden energy drop (what time of day)

Name ______________________________ Date ____________________

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems?
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Spots in front of eyes
- ☐ Recurring sore throats
- ☐ Teeth problems
- ☐ Headaches (where, when?
- ☐ Any other head or neck problems?
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Sore on lips or tongue
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Facial pain

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Cold hands and feet
- ☐ Blood clots
- ☐ Any other heart of blood vessel problems?
- ☐ Low blood pressure
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Difficulty in breathing
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐

Respiratory:

- ☐ Cough
- ☐ Bronchitis
- ☐ Pain with a deep breathe
- ☐ Production of phlegm, what color?
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Difficulty in breathing when lying down
- ☐ Any other lung problems?
- ☐ Asthma

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Poor appetite
- ☐ Any other problems with your stomach or intestines?

Genito-Urinary

- ☐ Pain upon urination
- ☐ Blood in Urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in urine flow
- ☐ Impotence
- ☐ Sores on genitals
- ☐ How many times per day do you urinate? ________
- ☐ Do you wake up to urinate? How often? ________
- ☐ Any particular color to your urine? ________
- ☐ Any other problems with your genital or urinary system?

Musculoskeletal

- ☐ Neck pain
- ☐ Muscle pain
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Any other joint or hone problems?

Reproductive and gynecologic

- ☐ # of pregnancies_____
- ☐ vaginal discharge
- ☐ menstrual clots
- ☐ # of lives births_____
- ☐ breast lumps
- ☐ unusual periods (heavy/light?)
- ☐ # of premature births
- ☐ menopause: age_____
- ☐ Spotting or pain between periods
- ☐ # of miscarriages
- ☐ irregular periods
- ☐ # of abortions
- ☐ menstrual pain

Date of last pap___________ Results:__________

Date of last period _______________Number of days between periods______________

Changes in body/psyche prior to period:______________

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

Is there any chance that you are pregnant now?___________

Neuropsychological

☐Seizures ☐Lack of coordination ☐Loss of balance

☐Areas of numbness ☐Depression ☐Poor memory

☐Concussion ☐Easily susceptible to stress ☐Anxiety

☐Bad temper ☐Tremors

Have you ever been treated for emotional problems? ______________________________

Have you ever considered or attempted suicide? ______________________________

Any other neurological or psychological problems? ______________________________

COMMENTS

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

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By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Eastern Therapeutics. 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 practitioners.

I understand that at times it may be necessary for the health care professionals working at this practice to confer regarding my treatment plan.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Heat Therapy/ Herbal Plasters: I understand that I may be given topical herbal plasters with or without heat therapy as part of my treatment to modify or prevent pain perception, eliminate muscle spasms, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These may include, but are not limited to skin discoloration, swelling, and skin tightness. I understand that I may refuse this treatment.

Reiki: I agree to receive reiki treatment.

Hypnotherapy: I agree to receive hypnotherapy.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: ______________________ **Date:** ______________

Printed Name: ______________________ **Date of Birth:** ______________

Address: ____

City: ______________ **State:** __________ **Zip Code:** __________ **Phone:** ______________

<u>I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.</u>

X______________________________ X______________________________

Patient's Signature Date <u>Explained by me and signed in my presence</u> Date

Cancellation Policy

We require twenty four hours notice of a cancellation. Special consideration will be taken for any cancelation of less than 24 hours and will handled on a case to case basis. We understand that life happens. Thank you.

Can't make your appointment? Call us at 508-668-6542; in case of after hours, please leave a message on our voice mail. This allows other clients to make an appointment with our acupuncturists.

Our Cancellation Policy is the following:

More than 24 Hours Notice – No charge.

Less than 24 Hours Notice OR No-Show – 100% Charge

Please sign below that you understand our policy regarding cancellations

Name:______________________________

Signature:___________________________

Date:_______________________________