Merrimack Valley Acupuncture
Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All your answers will be held absolutely confidential.* If you have questions, please ask. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the last section. Thank you.

DATE:	First Name:		Last Name:	
How did you hear about us? ❑ Patient ❑ Healthcare Provider ❑ Internet ❑ Other			Referred By:	
Date of Birth:	Age:	Height:	Weight:	❑ Male ❑ Female
Marital Status: ❑ Single ❑ Married ❑ Divorced				
Street	Town/City		State	Zip
Mailing address, if different:				
Home Phone	Cell Phone		Work Phone	
Email	Occupation			
Primary Care Provider & Phone				
Emergency Contact:				
Name (First & Last)	Phone#		Relation to you	

Have you been treated by Acupuncture or Chinese Medicine before? ❑ Yes ❑ No
What is the main problem that brought you here today?
How long ago did this problem begin? Please be specific.
Have you been given a diagnosis for this problem? If yes, what was the diagnosis and when was it given?
To what extent does this problem interfere with your daily activities (such as work, sleep, sex, etc.)?
What treatments have you tried? Did they work?

Patient Name: _____

PERSONAL HEALTH HISTORY
Significant Illnesses: Have you ever had cancer? If yes, which type(s)? Are you receiving active care from an MD or DO for your cancer? Have you ever had epilepsy? If yes, are you receiving active care from an MD or DO for your epilepsy? **NOTE: I cannot treat you if you are not receiving active care for your cancer and/or epilepsy. I require a letter from your treating healthcare provider in order to treat you.**

Do you have any implants (incl. pins, plates, joint replacement)? ❑ Yes ❑ No If so, where?	Do you have a Pacemaker? ❑ Yes ❑ No
Allergies to: ❑ Metal (specify type) ❑ Latex or adhesives ❑ Other: drugs, chemicals, foods, etc. (pls. specify)	
Last Physical Exam:	Last Dental Exam:
Last Chest X-Ray:	Last Eye Exam:

Surgeries & Other Hospitalizations

Year	Reason	Outcome

Significant Traumas (auto accidents, falls, etc.)

Year	Result

Medications (taken within the last 2 months)

Prescribed drugs, over-the-counter drugs (incl. vitamins, supplements, etc.), and any other alternatives (incl. herbs)

Medication	Strength	Frequency Taken	Purpose

HEALTH HABITS AND PERSONAL SAFETY	
Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
Stress	Occupational Stress (chemical, physical, psychological, etc.):

Patient Name: _____

HEALTH HABITS AND PERSONAL SAFETY									
	How does stress manifest for you (e.g. insomnia, irritability, over-eating, etc.)?								
Diet	Have you ever been on a restricted diet? If yes, what kind?								
	Please describe your average daily food intake:								
	Morning	Afternoon	Evening	Snacks:					
Water Intake	How much water do you drink each day?								
Caffeine	☐ None	# of cups/cans per day:	☐ Coffee	☐ Tea	☐ Cola				
Alcohol	Do you drink alcohol?					☐	Yes	☐	No
	How many drinks per week?	Are you concerned about the amount you drink?				☐	Yes	☐	No
Drugs	Do you use illicit drugs or drugs not prescribed to you? How often?					☐	Yes	☐	No
Tobacco	Have you ever used tobacco?					☐	Yes	☐	No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day					
	☐ # of years	☐ Or year quit							
Sex	Are you sexually active?					☐	Yes	☐	No
	If yes, are you trying for a pregnancy?					☐	Yes	☐	No
	If not trying for a pregnancy, list contraceptive or barrier method used:								

FAMILY HEALTH HISTORY			
Please note the relationship to you of those in your immediate family (parents, siblings, children) with these illnesses:			
	Relationship		Relationship
Cancer		Kidney Disease	
Diabetes		Drug or Alcohol Abuse	
Heart Disease		Mental Illness	
Blood Pressure: High/Low		Depression/Anxiety	
Stroke		Migraine Headaches	
Epilepsy		Obesity	
Allergies		Thyroid: under/over active	
Asthma		Ulcer	
Chronic Lung Disease		Gout	

	Present Age or Age at Death	Health (Good, Fair or Poor) If Deceased, cause of death		Present Age or Age at Death		Health (Good, Fair or Poor) If Deceased, cause of death
Father:			Children:			
Mother:						
Siblings:						

Patient Name: _____

WOMEN'S HEALTH

Age at onset of Menstruation:	Date of last menstruation:
Age of Menopause:	Are you pregnant? ☐ Yes ☐ No

If you no longer have a period, please answer questions about your menstrual cycle based on how it used to occur.

Do/did you experience PMS? (check all that apply)

☐ Breast tenderness ☐ Cramping ☐ Acne ☐ Changes in Bowels ☐ Bloating ☐ Headaches ☐ Nausea ☐ Fatigue

☐ Back Pain ☐ Sleep Disturbances ☐ Night sweats ☐ Hot ☐ Cold

Period every _____ days Do/did you have irregular periods? If yes, please describe

Do/did you have emotional changes with cycle? If yes, please describe

Color & Quality of Blood:	Pale Pink / Brownish /Dark Red/Bright Red		Watery / Moderate /Thick
☐ *Menstrual Pain:*	Sharp / Dull / Achy		Beginning / Middle / End of flow
☐ *Menstrual Clots:*	Size:	Color:	Beginning / Middle / End of flow
☐ *Unusual Periods:*	Heavy / Light / Stop & Start		Other:

Spotting or pain between periods? ☐ Yes ☐ No

☐ Vaginal Discharge: Clear/White/Yellow/Red Thin/Thick/Cheese-like Foul Odor

When does this discharge occur during your cycle?

☐	Vaginal Itching	☐	History of ovarian cysts	☐	Fibroids	☐	Sores on genitals
☐	Low Libido	☐	Discomfort or pain during intercourse				

Are you dealing with infertility issues at this time?	☐	Yes	☐	No	Have you tried Western Fertility treatments?	☐	Yes	☐	No

# of pregnancies _____ # Live births _____ # Premature births_____ # Miscarriages_____ # Abortions_____

Excessive bleeding or other issues with birth? If yes, please describe	☐	Yes	☐	No

Date of Last Pap Smear:	Date of last Mammogram:
Results:	Results: Breast Lumps?

MEN'S HEALTH

☐	Impotence	☐	Prostatitis	☐	Sores on genitals	☐	Premature Ejaculation
☐	Low Sperm Count	☐	Low Libido	☐	Involuntary Ejaculation		

Do you usually get up to urinate during the night? If yes, # of times _____	☐	Yes	☐	No
Do you feel pain or burning with urination?	☐	Yes	☐	No
Do you feel burning or have discharge from your penis?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No

Patient Name: _____

OTHER PROBLEMS					
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.					
General:					
☐	Fevers/Chills	☐	Cravings	Thyroid: ☐ under ☐ over active	
☐	Sweat Easily: day/night	☐	Fatigue	Weight: ☐ gain ☐ loss	
☐	Peculiar tastes or smells	☐	Sudden energy drop	Diabetes ☐ Type I (juvenile) ☐ Type II	
☐	Poor Sleep	☐	Strong thirst for beverages that are: Hot/Cold/Room temperature		

Current Infections:									
☐	Cold/Flu	☐	Hepatitis	☐	AIDS or HIV+	☐	Tuberculosis	☐	Herpes
Any other infections currently?									

Skin and Hair:									
☐	Loss of hair	☐	Dandruff	☐	Hives	☐	Eczema	☐	Psoriasis
☐	Itching	☐	Rashes	☐	Pimples/acne	☐	Recent Moles	☐	Ulcerations
Change in hair or skin texture:									
Any other hair or skin problems?									

Head, Eyes, Ears, Nose and Throat:							
☐	Headaches	☐	Glasses/contacts	☐	Glaucoma	☐	Poor hearing
☐	Migraines	☐	Cataracts	☐	Post nasal drip	☐	Ringing in ears: High/Low pitch
☐	Concussions	☐	Poor/blurry vision	☐	Sinus problems	☐	Earaches
☐	Jaw clicks	☐	Color blindness	☐	Nose Bleeds	☐	Recurrent sore throats
☐	Grinding teeth	☐	Night blindness	☐	Spots in front of eyes	☐	Sores on lips or tongue
☐	Facial pain	☐	Eye pain	Any other head problems?			

Cardiovascular:					
☐	Blood pressure: High/Low	☐	Swelling: hands/feet	☐	Chest pain
☐	Irregular heartbeat or palpitations	☐	Cold hands and feet	☐	Bleed or Bruise easily
☐	Mitral Valve Prolapse or Heart Murmur	☐	Phlebitis	☐	Blood clots
☐	Heart Attack	☐	Anemia	☐	Hemophilia
Any other heart or blood vessel problems?					

Respiratory:					
☐	Cough	☐	Coughing blood	☐	Asthma
☐	Bronchitis	☐	Pneumonia	☐	Pain with a deep breath
☐	Wheezing	☐	Shortness of breath	☐	Difficulty breathing when lying down

Patient Name: _____

Production of phlegm? If yes, what color?
Any other lung problems?

Gastrointestinal:					
☐	Nausea	☐	Abdominal pain or cramps	☐	Diarrhea
☐	Vomiting	☐	Intestinal Gas	☐	Constipation
☐	Changes in appetite	☐	Chronic laxative use	☐	Irritable Bowel Syndrome
☐	Indigestion/Belching/Acid Reflux	☐	Rectal pain	☐	Hemorrhoids
☐	Ulcer	☐	Black stools	☐	Blood in stools
How many bowel movements per day?					
Any other problems with your stomach or intestines?					

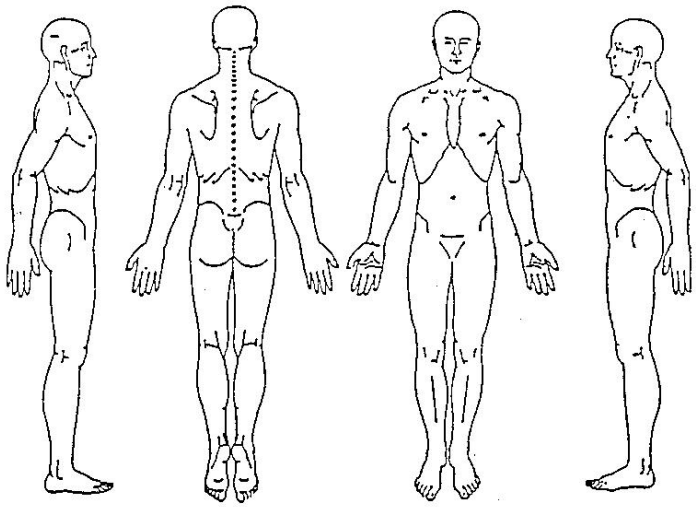
Genito-Urinary:					
☐	Urgency to urinate	☐	How many times per day do you urinate?	☐	Pain w/urination
☐	Unable to hold urine			☐	Blood in urine
☐	Decrease in urine flow	☐	Do you wake to urinate? How often?	☐	Kidney stones
☐	Urine color White/Yellow/Clear/Cloudy/Dark			☐	Kidney Disease
Any other problems with your genital or urinary system?					

Neuropsychological:					
☐	Seizures or Epilepsy	☐	Poor memory	☐	Anxiety
☐	Tremors	☐	Loss of balance	☐	Depression
☐	Stroke	☐	Dizziness or Fainting	☐	Easily angered
☐	Lack of coordination	☐	Areas of numbness	☐	Easily susceptible to stress
Have you ever been treated for drug abuse or addiction?			Have you ever been treated for emotional problems?		
Have you ever considered suicide?			Have you ever attempted suicide?		
Any other neuropsychological problems?					

Musculoskeletal:					
☐	Neck pain	☐	Shoulder pain	☐	Osteoarthritis
☐	Back pain	☐	Knee pain	☐	Rheumatoid Arthritis
☐	Hand/Wrist pain	☐	Foot/Ankle pain	☐	Fibromyalgia
☐	Muscle pain/weakness	☐	Hip pain	☐	Hernia
Any other joint or bone problem?					

Patient Name: _____

Pain Assessment: Please indicate any painful or distressed areas by circling the area:



Describe your pain:

Quality:	☐ Stabbing	☐ Burning	☐ Dull/achy
Location:	☐ Fixed location	☐ Pain moves around	
Frequency:	☐ Constant	☐ Intermittent	

Rate your pain level (0 = no pain, 10 = worst possible pain):

Present Pain: _____ Worse pain gets: _____ Best pain gets: _____

When is your pain worse (check all that apply)

☐ A.M. ☐ Mid-day ☐ P.M. ☐ with movement ☐ without movement ☐ Rain ☐ Heat

Is there anything else you would like to discuss?