

Merrimack Valley Acupuncture Health History Questionnaire

Please help us 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 our 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? <input type="checkbox"/> Patient <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Internet <input type="checkbox"/> Other				Referred By:
Date of Birth:	Age:	Height:	Weight:	<input type="checkbox"/> Male
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced				<input type="checkbox"/> Female
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

Patient Name: _____

PERSONAL HEALTH HISTORY	
Significant Illnesses:	
Do you have any implants (incl. pins, plates, joint replacement)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where?	Do you have a Pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to: <input type="checkbox"/> Metal (specify type) <input type="checkbox"/> Latex or adhesives <input type="checkbox"/> 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	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
Stress	Occupational Stress (chemical, physical, psychological, etc.):
	How does stress manifest for you (e.g. insomnia, irritability, over-eating, etc.)?

Patient Name: _____

HEALTH HABITS AND PERSONAL SAFETY											
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	<input type="checkbox"/> None	# of cups/cans per day:	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea		<input type="checkbox"/> Cola					
Alcohol	Do you drink alcohol?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	How many drinks per week?			Are you concerned about the amount you drink?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Drugs	Do you use illicit drugs or drugs not prescribed to you? How often?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tobacco	Do you use tobacco?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day		<input type="checkbox"/> Pipe - #/day		<input type="checkbox"/> Cigars - #/day				
	<input type="checkbox"/> # of years		<input type="checkbox"/> Or year quit								
Sex	Are you sexually active?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, are you trying for a pregnancy?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	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 family with any of 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:	Period every ____ days	
Age of Menopause:	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If you no longer have a period, please answer questions about your menstrual cycle based on how it used to occur.</i>			
Do you experience PMS? (check all that apply)			
<input type="checkbox"/> Breast tenderness <input type="checkbox"/> Cramping <input type="checkbox"/> Acne <input type="checkbox"/> Changes in Bowels <input type="checkbox"/> Bloating <input type="checkbox"/> Headaches <input type="checkbox"/> Nausea <input type="checkbox"/> Fatigue <input type="checkbox"/> Back Pain <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Night sweats <input type="checkbox"/> Hot <input type="checkbox"/> Cold			
Irregular Periods? If yes, please describe			
Emotional changes with cycle? If yes, please describe			
<hr/>			
<i>Color & Quality of Blood:</i>	Pale Pink / Brownish /Dark Red/Bright Red	Watery / Moderate /Thick	
<input type="checkbox"/> <i>Menstrual Pain:</i>	Sharp / Dull / Achy	Beginning / Middle / End of flow	
<input type="checkbox"/> <i>Menstrual Clots:</i>	Size:	Color:	Beginning / Middle / End of flow
<input type="checkbox"/> <i>Unusual Periods:</i>	Heavy / Light / Stop & Start	Other:	
Spotting or pain between periods?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<hr/>			
<input type="checkbox"/> Vaginal Discharge:	Clear/White/Yellow/Red	Thin/Thick/Cheese-like	Foul Odor
When does this discharge occur during your cycle?			
<input type="checkbox"/> Vaginal Itching	<input type="checkbox"/> History of ovarian cysts	<input type="checkbox"/> Fibroids	<input type="checkbox"/> Sores on genitals
<input type="checkbox"/> Low Libido	<input type="checkbox"/> Discomfort or pain during intercourse		
<hr/>			
Are you dealing with infertility issues at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you tried Western Fertility treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
# of pregnancies ____	# Live births ____	# Premature births ____	# Miscarriages ____ # Abortions ____
Excessive bleeding or other issues with birth? If yes, please describe			<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Last Pap Smear:		Date of last Mammogram:	
Results:		Results: Breast Lumps?	

MEN'S HEALTH			
<input type="checkbox"/> Impotence	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Sores on genitals	<input type="checkbox"/> Premature Ejaculation
<input type="checkbox"/> Low Sperm Count	<input type="checkbox"/> Low Libido	<input type="checkbox"/> Involuntary Ejaculation	
Do you usually get up to urinate during the night? If yes, # of times ____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel pain or burning with urination?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel burning or have discharge from your penis?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?			<input type="checkbox"/> Yes <input type="checkbox"/> 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:

<input type="checkbox"/>	Fevers/Chills	<input type="checkbox"/>	Poor Sleeping	<input type="checkbox"/>	Thyroid: under/over active
<input type="checkbox"/>	Sweat Easily: day/night	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Weight: gain/loss
<input type="checkbox"/>	Peculiar tastes or smells	<input type="checkbox"/>	Sudden energy drop	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Cravings	<input type="checkbox"/>	Strong thirst for beverages that are: Hot/Cold/Room temperature	<input type="checkbox"/>	Cancer Type:

Current Infections:

<input type="checkbox"/>	Common cold	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Flu	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	AIDS or HIV+

Any other infections currently?

Skin and Hair:

<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Ulcerations	<input type="checkbox"/>	Hives
<input type="checkbox"/>	Itching	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Pimples
<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	Loss of hair	<input type="checkbox"/>	Psoriasis

Recent Moles:

Change in hair or skin texture:

Any other hair or skin problems?

Head, Eyes, Ears, Nose and Throat:

<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	Glasses/contacts	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Concussions	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Facial pain
<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	Poor/blurry vision	<input type="checkbox"/>	Poor hearing
<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	Color blindness	<input type="checkbox"/>	Ringing in ears: High/Low pitch
<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	Night blindness	<input type="checkbox"/>	Earaches
<input type="checkbox"/>	Jaw clicks	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	Recurrent sore throats
<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	Spots in front of eyes	<input type="checkbox"/>	Sores on lips or tongue

Any other head or neck problems?

Cardiovascular:

<input type="checkbox"/>	Blood pressure: High/Low	<input type="checkbox"/>	Swelling: hands/feet	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Irregular heartbeat or palpitations	<input type="checkbox"/>	Cold hands and feet	<input type="checkbox"/>	Bleed or Bruise easily
<input type="checkbox"/>	Mitral Valve Prolapse or Heart Murmur	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Hemophilia

Any other heart or blood vessel problems?

Patient Name: _____

Respiratory:		
<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pain with a deep breath
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Difficulty breathing when lying down
Production of phlegm? If yes, what color?		
Any other lung problems?		

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

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

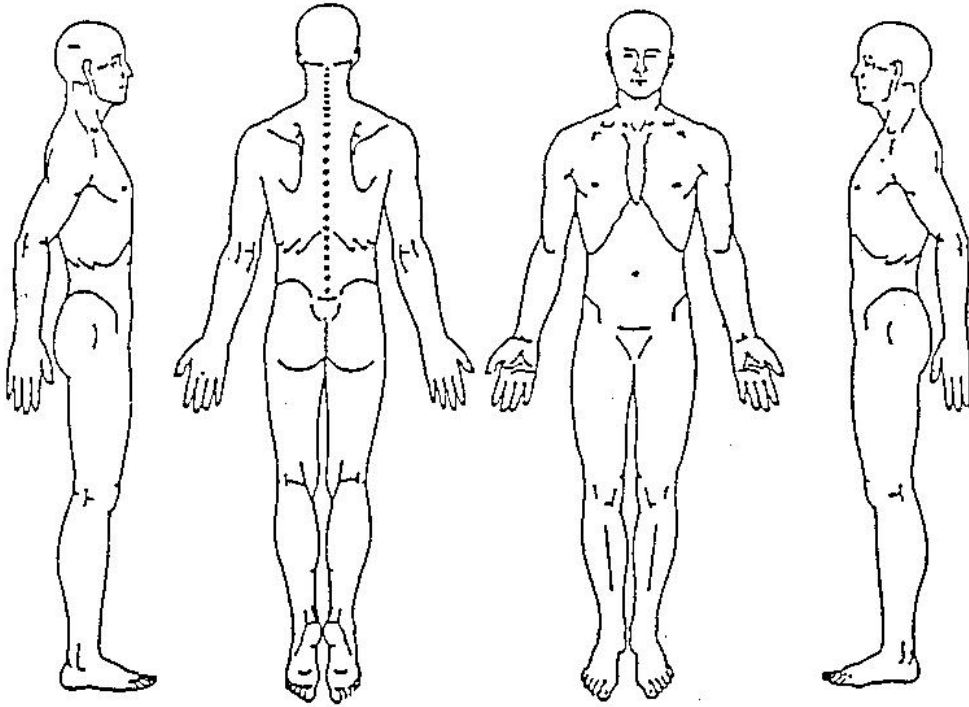
Neuropsychological:		
<input type="checkbox"/> Seizures or Epilepsy	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Tremors	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Depression
<input type="checkbox"/> Stroke	<input type="checkbox"/> Dizziness or Fainting	<input type="checkbox"/> Easily angered
<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> 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:		
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Back pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Rheumatoid Arthritis

Patient Name: _____

Musculoskeletal:		
<input type="checkbox"/> Hand/Wrist pain	<input type="checkbox"/> Foot/Ankle pain	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Muscle pain/weakness	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Hernia
Any other joint or bone problem?		

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?