Stone Acupuncture
2016 OceanStreet 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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