Blackstone Valley Acupuncture

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Blackstone Valley Acupuncture Health History Form

Name:_____ Date: _____

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

Street: _____City: _____ State: ___ Zip:_____

Home Phone: _____ Cell Phone:_____

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

Family Physician: _____ Emergency Contact / Phone: _____

Occupation: _____ Referred by: _____

BCBS Member #_____ **Your relationship to Insured**:_____

Primary Insured Name:_____ **Primary Insured Date of Birth**:_____

Have you been treated with Acupuncture before? Y / N

How did you hear about us: Friend Internet Referral Facebook
Other:_____

Please list up to **2 main health concerns** you would like treated:

#1_____
How does this affect you? _____
When did this start? _____
What makes it better?_____
What makes it worse? _____
Have you seen a doctor? _____

#2_____
How does this affect you? _____
When did this start? _____
What makes it better?_____
What makes it worse? _____
Have you seen a doctor? _____

PAST PERSONAL MEDICAL HISTORY

Please check all that apply to you

	Anemia		HIV/Aids
	Auto-immune disorder		Kidney disease
	Cancer		Pacemaker
	Chemical Dependency		Rheumatic Fever
	Diabetes		Seizures
	Glaucoma		Stroke
	Herpes		Thyroid disorder
	Hepatitis/Liver disease		Heart Disease

Allergies: Please List

_____

_____

CURRENT MEDICATIONS

Please list anything taken within the past 2 months including prescriptions, vitamins, supplements, etc.

_____

_____

_____

_____

HOSPITALIZATION, SURGERIES, INJURIES

Please include dates

_____

_____

LIFESTYLE

Do you follow any special diet (vegetarian, vegan, raw, macrobiotic, medically prescribed, etc.?

_____

How often do you eat every day? _____

Do you have a regular exercise program? Yes __ No __ If yes, please describe:

_____

_____

How much of the following do you drink per day:

Alcoholic beverages _____

Caffeinated beverages _____

Water (8 oz. cups) _____

Do you smoke? Yes ___ No __ If so, many cigarettes per day? _____

FOR THE FOLLOWING PLEASE CHECK ALL THAT APPLY

GENERAL

	Fevers/Chills		Strong thirst for hot or cold drinks		Cravings for _____
	Change in appetite		Sudden energy drop at _____time of day		Fatigue
	Night sweats		Weight gain/loss		Cold hands / feet
	Peculiar tastes / smells		Unusual sweating		Sweat easily

SLEEP

 # hours of sleep per night: ___

	Restless or light sleep		Waking _____ times per night at _____am/pm
	Difficulty falling asleep		Wake to urinate_____ times per night
	Difficulty staying asleep		Unrested upon waking
	Disturbing dreams		

HEAD, EYES, EARS, NOSE & THROAT

	Eye Strain/Pain		Poor/blurry vision		Glaucoma/cataracts		Tearing eyes
	Red/Itchy eyes		Ringing in ears		Ear aches		Poor hearing
	Migraines		Sinus Problems		Nose bleeds		TMJ/jaw problems
	Facial pain		Frequent sore throat		Lip or mouth sores		Tooth/Gum problems
	Concussion		Spots in vision / floaters		Tension Headaches		Grinding Teeth
	Dizziness						Dry Eyes

SKIN

	Dry skin/hair		Dermatitis		Bruise easily		Itchy skin
	Psoriasis		Dry/brittle nails		Acne		Recent moles
	Hair loss		Eczema		Oily skin		Recent change in skin/hair
	Rashes		Dandruff		Hives		Other:

RESPIRATORY

	Cough		Coughing blood		Asthma
	Pneumonia		Chest tightness		Wheezing
	Shortness of breath		Phlegm (color)_____		Pain with deep breath
	Difficulty breathing lying down		Chronic Bronchitis		Other:

CARDIOVASCULAR

	Chest pain/ pressure		Shortness of breath		Palpitations		Fainting
	Swelling/Edema Hands/Feet		Irregular heartbeat		High blood pressure		Stroke
	Heart disease		Blood clots		Low blood pressure		Varicose Veins
	Heart Murmur		Blocked arteries		Other:		

GASTROINTESTINAL

	Ulcers		Constipation		Diarrhea		Bloating
	Belching		Colitis		Blood in stool		Excessive gas
	Indigestion		Rectal Pain		Abdominal pain		Poor appetite
	Acid Reflux GERD		Chronic laxative use		Irritable Bowel Syndrome		Excessive appetite
	Heartburn		Bad Breath		No desire to drink		Cramping
	Nausea/Vomiting		Hemorrhoids		Hernia		Slow Digestion

URINARY

	Frequent urination		Burning sensation		Pain with urination
	Kidney Stones		Urination frequency __X/day		Cloudy urine
	Waking at night to urinate		Excessive amount of urination		Unable to hold urine
	Scanty urination		Blood in urine		Dribbling after urination
	Urgent urination		Decreased/interrupted flow		Other:

MUSCULOSKELETAL

	Neck pain		Neuropathy		Numbness /tingling
	Muscle pain		Hand / wrist pain		Knee pain
	Sprains		Carpal tunnel		Muscle spasm
	Back pain: Low__ Mid __ Upper __		Hip pain		Foot / ankle pain
	Shoulder pain		Sciatica		Tendonitis
	Bursitis		Arthritis		Fibromyalgia
	Rotator cuff injury		Herniated disk		Plantar Fascitis

EMOTIONAL

	Irritability		Bipolar		Sadness / Grief
	Anxiety		ADHD / ADD		Mood swings
	Panic attacks		Easily susceptible to stress		Obsessive thoughts
	Nervousness		Worry		Compulsive thoughts
	Depression		Indecision		Anger / Frustration

Have you ever been treated for emotional issues? Yes ____ No ____
Have you ever considered suicide? Yes ____ No ____

FEMALE REPRODUCTIVE

Are you or could you be pregnant? Yes___ No ___
Are you using birth control? Yes ___ No ___

Age of first period: ___ Date of last period: ___ Days between periods: ___
# of pregnancies: ____ # of live births: ___ # of miscarriages: ___

	Heavy/scanty periods		Painful periods		Vaginal dryness
	Mid-cycle bleeding		Hysterectomy		Menopause
	Difficulty getting pregnant		Endometriosis		Irregular periods
	Breast Lumps		Infertility Treatments		Ovarian cysts
	Genital sores		Menstrual clots		Polycystic ovarian disease
	Vaginal discharge		Uterine fibroids		Yeast infections
	Low libido		STD		Hot flashes / night sweats
	PMS		Osteoporosis		Osteopenia