

Ancient Path Acupuncture and Herbs

394 Lowell Street, Suite 16
Lexington, MA 02420

Tel: 781-863-0066
Fax: 914-885-1731



Acupuncture & Herbal Clinic of Westborough

57 E Main Street, Suite 203
Westborough, MA 01581

Tel: 508-366-5773
Fax: 508-366-6523

www.ancientpathweb.com

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 held absolutely confidential. If you have any questions, please ask the practitioner. 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.

Name		Date of Birth		Home Phone	
Street/City				Work Phone	
State	Zip	E-mail		Cell Phone	
Occupation		Marital Status		Height	Weight
Emergency Contact (Name & Phone)					
Family Physician			Referred by		
Insurance Company			Policy Number		

Main Problem(s) you would like us to help you with:
How long ago did this problem begin? (please be specific)
To what extend does this problem interfere with your daily activities (such as work, sleep, sex, etc.)?
Have you been given a diagnosis for this problem? If yes, what is it?
What kinds of treatment have you tried?
Have you ever been treated by oriental medicine (including acupuncture, herbs, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No

PAST MEDICAL HISTORY (please include date)
Significant Illness
<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Hepatitis <input type="checkbox"/> Seizures <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other
Surgeries
Significant trauma (auto accidents, falls, etc.)
Allergies (drugs, chemicals, foods, etc.)

FAMILY MEDICAL HISTORY
<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Asthmas <input type="checkbox"/> Seizures <input type="checkbox"/> Allergies <input type="checkbox"/> Other
Medicines taken within the last two months (drugs, vitamins, herbs, etc.)

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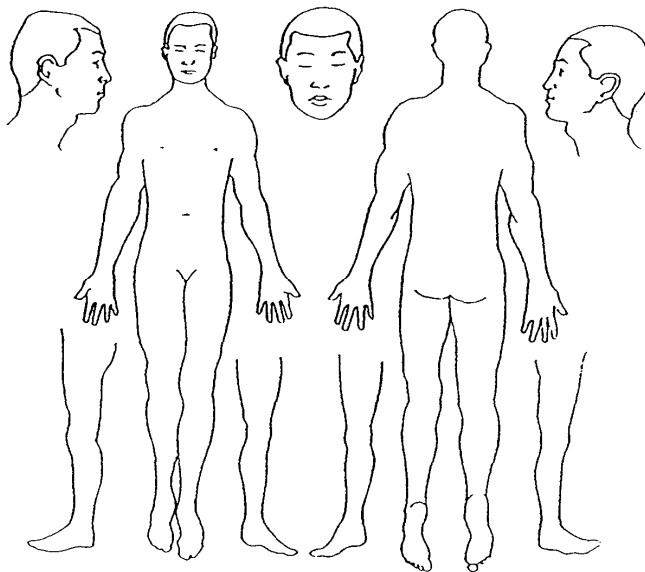
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Occupational stress (chemical, physical, psychological, etc.)		
Do you have a regular exercise program? If yes, please describe it.		
Have you ever been a restricted diet? If yes, what kind?		
Please describe your average daily diet		
Morning	Afternoon	Evening
How much water do you drink per day?		
Do you smoke? If yes, how much per day (week)?		
How much caffeinated coffee, tea, or cola do you drink per day?		
How much alcoholic drink/beverages do you drink per day?		
Please describe any use of drugs for non-medical purpose:		

PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS



PLEASE CHECK IF YOU HAVE HAD (IN THE LAST THREE MONTHS):

GENERAL			
<input type="checkbox"/> Poor Sleeping	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills
<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Cravings	<input type="checkbox"/> Change in Appetite	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Bleed or Bruise Easily	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Peculiar Taste or Smell
<input type="checkbox"/> Strong Thirst (hot or cold drinks)	<input type="checkbox"/> Sudden Energy Drop (what time of day?)		

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Name _____

SKIN & 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"/> Change in Hair or Skin Texture | <input type="checkbox"/> Other Problem | | |

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in front of Eyes | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nose Bleed | <input type="checkbox"/> Recurrent Sore Throat | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Sores on Lips or Tongue | <input type="checkbox"/> Teeth Problem | <input type="checkbox"/> Jaw Clicks | <input type="checkbox"/> Headache (where, when?) |
| <input type="checkbox"/> Other Problem | | | |

CARDIOVASCULAR

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold Hands and Feet | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Difficulty in Breathing | |
| <input type="checkbox"/> Other Heart or Blood Vessel Problem | | | |

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"/> Difficulty in Breathing When Lying Down | |
| <input type="checkbox"/> Production of Phlegm (what color?) | | <input type="checkbox"/> Other Lung Problem | |

GASTROINTESTINAL

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in Stools |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramps | <input type="checkbox"/> Chronic Laxative Use | | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Other Stomach or Intestine Problem | | | |

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GENITO-URINARY

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> How Many Times per Day Do You Urinate? | <input type="checkbox"/> Pain upon Urination | <input type="checkbox"/> Blood in Urine | |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Decrease in Urine Flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sore on Genitals | <input type="checkbox"/> Wake up to Urinate (how often?) | |
| <input type="checkbox"/> Particular Color to Your Urine (what color?) | <input type="checkbox"/> Other Genital or Urinary System Problem | | |

MUSCULOSKELETAL

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot / Ankle Pain | <input type="checkbox"/> Hand / Wrist Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Other Joint or Bone Problem | | |

REPRODUCTIVE AND GYNECOLOGIC

- # of Pregnancies _____ # of Live Birth _____ # of Premature Birth _____ # of Miscarriage _____
- # of Abortion _____ Vaginal Discharge Menstrual Clots Breast Lumps
- Unusual Periods (heavy, light, etc.) Spotting or Pain between Periods
- Menstrual Pain Irregular Periods Menopause (age _____) Age of 1st Menses _____
- Date of Last Period _____ # of Days Period Lasts _____ # of Days between Periods _____
- Date of Last Pap _____ Results: _____
- Do you notice any change 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

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Areas of Numbness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Easily Susceptible to Stress | <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Tremors | |
- Have you ever been treated for emotional problems? (when? What?)
- Have you ever considered or attempted suicide?
- Any other neurological or psychological problem?

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