**Health History**

Acupuncture Plus Yoga

481 Great Road (Rt 2A)

Acton, MA 01720

978-266-9889

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| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  (FIRST) (LAST)  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_ Phone(Day):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Evening):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Name & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_  Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever been treated by acupuncture? Y / N |

**MAIN CONCERN**: Mark on the scale ranking the severity of the condition from 1-10, with 1 being barely noticeable and 10 being the worst ever, and circle the items that make it better or worse. You may also fill in any other unlisted factors that make it better or worse.

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| **Main Concern:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  RANK SEVERITY: 1 - - - 2 - - - 3 - - - 4 - - - 5 - - - 6 - - - 7 - - - 8 - - - 9 - - - 10  When did this start? \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ (give month/year to best of ability)  Did any specific event precipitate it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is it **better** with (circle): ---heat---cold---damp---weather---exercise---rest  Better with other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is it **worse** with (circle): ---heat---cold---damp---weather---exercise---rest  Worse with other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has it been diagnosed by a western doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How does it impair your daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Second Most Important Concern.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rate Severity from **1-10** as above \_\_\_\_\_\_\_\_

**Third Most Important Concern.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rate Severity from **1-10** as above \_\_\_\_\_\_\_\_

**HISTORY OF INJURIES/SURGERIES**

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| Please note what happened, body area and date or age: |

**MEDICATIONS**

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| Please list any medications (prescribed and OTC), vitamins or supplements you are currently taking:  MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **HABITS:** Amount/week, if quit, when?  Coffee/Tea: \_\_\_\_\_\_\_\_\_\_\_\_\_\_/wk Alcohol: \_\_\_\_\_\_\_drinks/wk  Soda: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/wk Tobacco: \_\_\_\_\_\_\_\_\_\_\_/wk  Sugar: \_\_\_\_\_\_\_\_\_\_\_grams/Day Recreational Drugs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **EXERCISE** (type, frequency and amount):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How many glasses of H2O/day?  \_\_\_\_\_\_\_/day  What is your daily level of stress from  1-10 with 10 being the worst?  \_\_\_\_\_\_\_/10 |

**TEMPERATURE**

|  |  |
| --- | --- |
| \_\_\_Night sweats  \_\_\_Spontaneous sweats  \_\_\_Hot flashes  \_\_\_Hot face | \_\_\_Excess thirst/ thirst for **hot** or **cold** drinks (Circle)  \_\_\_Hot face  \_\_\_Cold hands/ feet  Do you tend to feel **colder** or **warmer** than most people? (Circle) |

**HEAD**

|  |  |  |
| --- | --- | --- |
| \_\_\_Eye Strain  \_\_\_Eye Floaters  \_\_\_Dry Eyes  \_\_\_Itchy eyes | \_\_\_Tinnitus (ear ringing)  \_\_\_Sinus Issues  \_\_\_Mouth sores  \_\_\_Frequent sore throat  \_\_\_TMJ | \_\_\_Headaches or Migraines  \_\_\_Dizziness / vertigo/ lightheadedness  \_\_\_Seizures  \_\_\_Foggy- headedness  \_\_\_Poor memory |

**CHEST**

|  |  |
| --- | --- |
| \_\_\_Palpitations  \_\_\_Shortness of breath  \_\_\_Asthma | \_\_\_Heart Disease  \_\_\_Low/ High Blood Pressure |

**DIGESTION**

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| --- | --- | --- |
| \_\_\_Poor appetite  \_\_\_Excessive hunger  \_\_\_Bad breath  \_\_\_Acid reflux  \_\_\_Heartburn | \_\_\_Nausea  \_\_\_Vomiting  \_\_\_Belching  \_\_\_Gas  \_\_\_Bloating | How often do you have a bowel movement? \_\_\_times/\_\_\_day(s)  \_\_\_Hard stool \_\_\_Hard to pass \_\_\_Incomplete stool  \_\_\_Loose stool \_\_\_Watery stool \_\_\_Blood/pus in stool  \_\_\_Crohn’s \_\_\_Colitis \_\_\_IBS \_\_\_Gastroparesis |

**SKIN**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_Dryness  \_\_\_Itching  \_\_\_Oily | \_\_\_Eczema  \_\_\_Psoriasis  \_\_\_Rosacea | \_\_\_Acne  \_\_\_Dry brittle nails  \_\_\_Rashes | \_\_\_Dandruff  \_\_\_Hair loss  \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**URINATION**

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| **Circle color:** Dark / Light / Clear  **Circle Volume:** Scant / Copious | \_\_\_Urgency  \_\_\_Frequency  \_\_\_Hx of UTIs | \_\_\_Incontinence  \_\_\_Waking to urinate  # of times per night \_\_\_\_\_\_\_\_ |

**MUSCULO-SKELETAL**

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| --- | --- | --- |
| \_\_\_Arthritis (**Osteo/Rheuma**)  \_\_\_Tendonitis  \_\_\_Bursitis  \_\_\_Bunions | \_\_\_Back pain **( Upper / Mid /Low )**  \_\_\_Sciatica  \_\_\_Acute sprain or strain  \_\_\_Carpal tunnel | \_\_\_Frozen shoulder  \_\_\_Knee pain  \_\_\_**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ENERGY**

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| --- | --- | --- |
| \_\_\_Fatigue  \_\_\_Body/limbs feel heavy | \_\_\_”Tired but wired”  \_\_\_Tired after eating | \_\_\_Reduced immunity  (such as due to auto-immune disease or chemo) |

**SLEEP**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_ hours/night  What time do you fall asleep? \_\_\_\_\_\_  What time do you wake up? \_\_\_\_\_\_ | \_\_\_Insomnia  \_\_\_Hard to fall asleep  \_\_\_Hard to stay asleep | \_\_\_Restless sleep  \_\_\_Dream-disturbed sleep  \_\_\_Tired in A.M. |

**EMOTIONS**

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| --- | --- |
| **\_\_\_** Irritability  \_\_\_Sadness  \_\_\_Depression | \_\_\_Anxiety  \_\_\_Mood swings  \_\_\_**Other**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FEMALE REPRODUCTIVE**

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| --- | --- | --- |
| **Age of first period:**\_\_\_\_\_\_ **Date of last period:**\_\_\_\_/\_\_\_\_/\_\_\_\_  **Length of period:**\_\_\_\_\_\_ **Length of full cycle:**\_\_\_\_\_\_ **Are cycles regular?** Y / N  **Are you pregnant?** Y / N **Total number of pregnancies:**\_\_\_\_\_\_ **Live births:**\_\_\_\_\_\_\_ | | |
| \_\_\_Spotting  \_\_\_Clots  \_\_\_Heavy flow  \_\_\_Light/Scanty flow  \_\_\_Frequent Yeast infections  \_\_\_Vaginal dryness  \_\_\_Low libido | | \_\_\_Cramps before/during period  \_\_\_Breast tenderness  \_\_\_PMS/ Emotional changes  \_\_\_Bloating  \_\_\_Insomnia  \_\_\_Tired after period  \_\_\_**Other**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Menopause**  **Age of last menses:**\_\_\_\_\_\_ | \_\_\_\_Hot flashes: \_\_\_\_\_\_x/day \_\_\_Sleep issues  \_\_\_\_Night sweats \_\_\_\_\_x/week \_\_\_Low libido | |

**MALE REPRODUCTIVE**

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| **\_\_\_**Erectile dysfunction  \_\_\_Premature Ejaculation  \_\_\_Prostate problems | \_\_\_Testicular pain/swelling  \_\_\_Low libido |

**CONSENT TO TREATMENT & OFFICE POLICIES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the acupuncturists at Acupuncture Plus Yoga to administer treatment of acupuncture and adjunctive techniques relevant to my diagnosis. The patient always has the right to refuse any treatment. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is recommended. Treatment may include, but is not limited to, the following:

1. Insertion of various style and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using conventional heat lamp or moxibustion (Artemesia Vulgaris). With any heat treatment exists the risk of burn.
3. Massage technique or gua sha. This technique may cause redness on the skin at the site of treatment which may last approximately 1-7 days. Slight bruising and tenderness may persist after treatment.
4. The placement of suction cups on the skin. These may produce a red or purple mark on the skin at the site of the cup that may last approximately 1-7 days. Slight bruising and tenderness may persist after the treatment.
5. Electrical stimulation of the needles that may be used producing a tapping sensation at the needle location.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment and have been given the opportunity to ask questions pertaining to the treatment. I also understand that there is always a possibility of an unexpected complication and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantee can be made concerning the results of treatment.

**I understand that Acupuncture Plus Yoga requires 24 hours’ notice for a cancelled appointment. If I cancel without 24 hours’ notice, I understand that I will be charged the full price of treatment.**

Payment for all services is due at the time of the visit. Acupuncture Plus Yoga accepts cash and checks.

If any of these policies presents a problem for you, or prevents you from having acupuncture care, please do not hesitate to speak with us about it.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_