CONCORD CENTER
Acupuncture
& HERBAL MEDICINE

Concord Center Acupuncture and Herbal Medicine, LLC
676 Elm Street, Suite 100, Concord, MA 01742
TEL: 978.369.9400
www.concordcenteracupuncture.com

Welcome!

Below you will find our health history form. Please complete this questionnaire as thoroughly as possible and bring it with you to your first appointment.

Your first appointment will last 90 minutes. Appointments thereafter are 60 minutes. Please arrive 15 minutes early to your first appointment, as there will be additional registration.

We have a 24 hour cancellation policy. We ask that you give 24 hours advance notice if you need to cancel or reschedule your treatment.

For best results from your acupuncture treatment, eat moderately within three hours of your treatment. **It is best not to come on an empty stomach.** Please also wear loose and comfortable clothing to your appointment.

If you have any questions feel free to call us at (978) 369-9400 or visit our website at www.concordcenteracupuncture.com for more information on acupuncture and Chinese herbal medicine. We look forward to meeting you!

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Health History

Name: _____ Date: _____

Street: _____ City: _____ State: _____

Zip Code: _____ Day Phone: _____ Evening Phone: _____

Date of Birth: ____ / ____ / ____ Age: ____ Gender: M / F Email: _____

Height: _____ Weight (current): _____ Weight (past maximum): _____

Please identify the health concerns that you would like us to help you with in order of importance:

1. _____ When did this problem begin? _____

   Medical diagnosis: _____

   How does this condition interfere with daily activities such as work, sleep, and sex? _____

   _____

   What types of treatment you have tried? _____

2. _____ When did this problem begin? _____

   Medical diagnosis: _____

   How does this condition interfere with daily activities such as work, sleep, and sex? _____

   _____

   What types of treatment you have tried? _____

3. _____ When did this problem begin? _____

   Medical diagnosis: _____

   How does this condition interfere with daily activities such as work, sleep, and sex? _____

   _____

   What types of treatment you have tried? _____

When were you last seen by a physician? _____ For what reason? _____

What is you most recent blood pressure reading? _____ When was this taken? _____

Do have any reason to believe that you are pregnant? Y / N

Do you have any infection diseases? Y / N If yes, please identify: _____

Do you have a pace maker? Y / N

Do you have any metal implants? Y / N

Please list any food, drugs, medications or substances to which you are hypersensitive or allergic:

_____

_____

_____

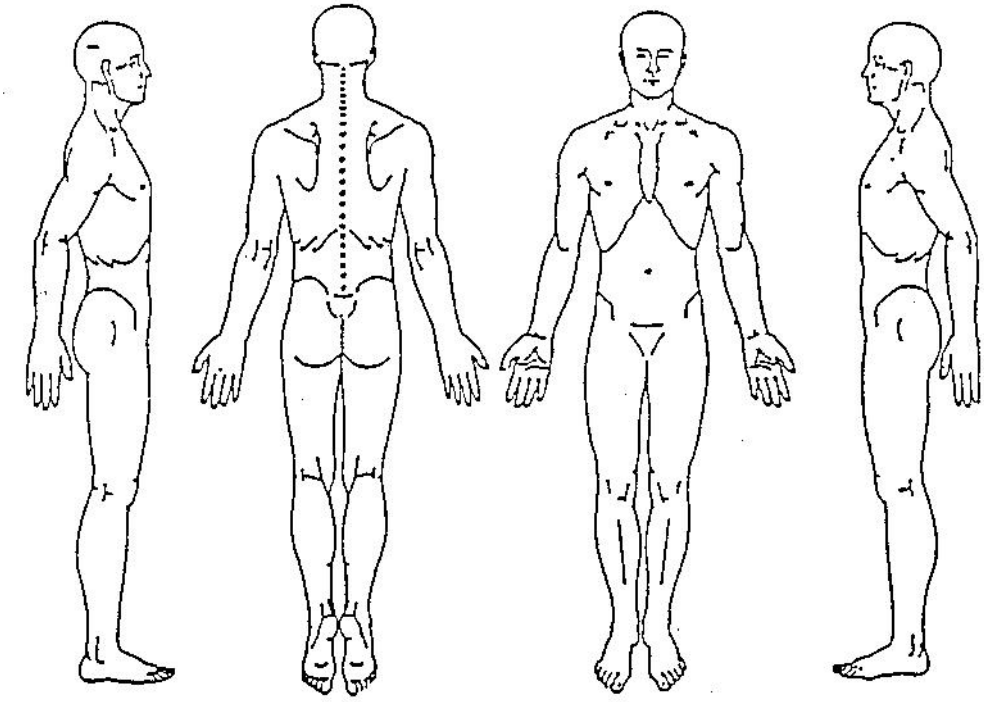
Please list all medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking and the reason for their use:

Medication/Supplement	**Dose**	**Reason for taking**

Please list all hospitalizations and surgeries you have had during the course of your lifetime:

Date	**Procedure**	**Reason**

Please indicate any painful or distressed areas by circling the area.



Lifestyle

How many meals per day do you typically eat?

Please describe your typical breakfast, lunch, dinner and snacks:

Breakfast:

Lunch:

Dinner:

Snacks:

How many glasses of water per day do you typically drink

How many cups of caffeinated coffee/tea/soda do you drink each day?

How many alcoholic beverages do you drink per week?

How many cigarettes do you smoke each day?

Do you use any prescription or non-prescription drugs recreationally? Y / N

How often do you exercise? Please describe your exercise routine:

How many hours per night do you sleep? Do you wake rested? Y / N

What is you occupation?

How many hours per week do you work? Do you enjoy your work? Y / N

Circle the highest level of education completed:

Grade School Middle School High School Bachelors Masters Doctorate Post-Doc

Do you have a religious/spiritual practice or community?

List your interests and hobbies:

Childhood Illnesses (check all that apply)

☐ Scarlet Fever Diptheria	☐ Measles	☐ Other: _____
☐ Rheumatic Fever	☐ German Measles	
☐ Mumps	☐ Chicken Pox	

Immunizations (check all that apply)

☐ Polio	☐ Pertussis	☐ Hepatitis
☐ Tetanus	☐ Diptheria	☐ Other: _____
☐ Rubella/Mumps	☐ Hib	

Family History
(check all those that apply to either your grandparents, parents, siblings, spouse or children)

	Grandparents	Parents	Siblings	Spouse	Children
Cancer (specify): _____	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

General Health and Immunity (check all that apply)

☐ Fevers	☐ Slow Wound Healing	☐ Cancer (specify): _____
☐ Sweat Easily	☐ Chronic Infections	☐ HIV/AIDS
☐ Night Sweats	☐ Bleed or Bruise Easily	
☐ Chills	☐ Chronic Fatigue Syndrome	
☐ Cold Hands	☐ Fibromyalgia	
☐ Cold Feet	☐ Frequent Common Colds	
☐ Fatigue	☐ Anemia	

Emotional (check all that apply)

☐ Mood Swings	☐ Panic Attacks	☐ Apathy
☐ Nervousness	☐ Depression	☐ Sadness
☐ Mental Tension	☐ Worry	☐ Crying
☐ Poor Sleep	☐ Fear	☐ Thoughts of Suicide
☐ Nightmares	☐ Anger	☐ Attempted Suicide
☐ Anxiety	☐ Rage	☐ Other:

Skin and Hair (check all that apply)

☐ Rashes	☐ Hives	☐ Changes in Hair Texture
☐ Itching	☐ Pimples	☐ Changes in Skin Texture
☐ Psoriasis	☐ Recent Moles	☐ Other:
☐ Eczema	☐ Loss of Hair	
☐ Ulcerations	☐ Dandruff	

Head, Eye, Ear, Nose and Throat (check all that apply)

☐ Impaired Vision	☐ Nose Bleeds	☐ Teeth Problems
☐ Eye Pain/Strain	☐ Impaired Hearing	☐ Mouth/Tongue Sores
☐ Glaucoma	☐ Ear Ringing	☐ Headaches
☐ Cataracts	☐ Earaches	☐ Migraines
☐ Glasses/Contacts	☐ Frequent Sore Throats	☐ Concussion
☐ Color Blindness	☐ Teeth Grinding	☐ Sinus Problems
☐ Blurry Vision	☐ TMJ/Jaw Problems	☐ Hay Fever
☐ Eye Tearing/Dryness	☐ Bleeding Gums	
☐ Spots in Front of Eyes	☐ Bad Breath	

Respiratory (check all that apply)

☐ Pneumonia	☐ Pleurisy	☐ Tuberculosis
☐ Bronchitis	☐ Difficulty Breathing	☐ Other:
☐ Persistent Cough	☐ Asthma	
☐ Shortness of Breath	☐ Emphysema	

Cardiovascular (check all that apply)

☐ Heart Disease	☐ Irregular Heartbeat	☐ Phlebitis
☐ Palpitations	☐ Fainting	☐ High Cholesterol
☐ Chest Pain	☐ High Blood Pressure	☐ Arterial Sclerosis
☐ Stroke	☐ Low Blood Pressure	☐ Bleed or Bruise Easily
☐ Swollen Ankles/Feet	☐ Rheumatic Fever	
☐ Swollen Hands	☐ Varicose Veins	
☐ Heart Murmurs	☐ Bloods Clots	

Gastrointestinal (check all that apply)

☐ Ulcers	☐ Nausea/Vomiting	☐ Black Stool
☐ Changes in Appetite	☐ Heartburn/Acid Reflux	☐ Chronic Laxative Use
☐ Weight Loss	☐ Epigastric Disease	☐ Rectal Pain/Itching
☐ Weight Gain	☐ Gallbladder Disease	☐ Hemorrhoids
☐ Strong Thirst	☐ Liver Disease	☐ Other:
☐ Abdominal Pain	☐ Hepatitis B or C	
☐ Indigestion	☐ Diarrhea	
☐ Belching	☐ Constipation	
☐ Gas	☐ Blood in Stool	

Genito-Urinary Tract (check all that apply)

☐ Kidney Disease	☐ Unable to Hold Urine	☐ Kidney Stones
☐ Kidney Stones	☐ Urine Dribbling	☐ Genital Sores
☐ Frequent UTI	☐ Frequent Urination	☐ Genital Itching
☐ Blood in Urine	☐ Frequent Urination at Night	
☐ Painful Urination	☐ Scanty Urine Flow	
☐ Urgency to Urinate	☐ Profuse Urine Flow	

Female Reproductive (check all that apply)

☐ Irregular Cycles	☐ Difficulty Conceiving	☐ Bleeding Between Cycles
☐ Vaginal Discharge	☐ Nipple Discharge	☐ PMS
☐ Menopausal Symptoms	☐ Menstrual Clots	☐ Genital Sores/Itching
☐ Breast Lumps	☐ Painful Periods	☐ Infertility
☐ Breast Tenderness	☐ Heavy Menstrual Flow	☐ Sexually Transmitted Dis-
☐ Premenstrual Problems	☐ Scanty Menstrual Flow	ease

Menstrual and Birthing History

When was you last PAP? _____	What form of birth control do you use? ____
When was your last menstrual period? _____	How many pregnancies have you had?____
At what age did you first menstruate? ____	How many miscarriages have you had? ____
How many days does your menses last? ____	How many abortions have you had? ____
How many days is your menstrual cycle? ____	How many live births have you had? ____

Male Reproductive (check all that apply)

☐ Sexual Difficulties	☐ Low Sperm Motility	☐ Penile Discharge
☐ Impotence	☐ Prostate Problems	☐ Genital Sores/Itching
☐ Premature Ejaculation	☐ Prostate Cancer	☐ Sexually Transmitted Dis-
☐ Spermatorrhea	☐ Testicular Pain/Swelling	ease
☐ Low Sperm Count	☐ Testicular Cancer	

Musculoskeletal (check all that apply)

☐ Neck/Shoulder Pain	☐ Muscle Spasms/Cramps	☐ Joint Pain (specify where):
☐ Low Back Pain	☐ Leg Pain	
☐ Upper Back Pain	☐ Restless Leg Syndrome	_____
☐ Mid Back Pain	☐ Arm Pain	

Neurologic (check all that apply)

☐ Vertigo/Dizziness	☐ Loss of Balance	☐ Poor Memory
☐ Paralysis	☐ Seizures/Epilepsy	☐ Tremors
☐ Numbness/Tingling	☐ Brain Tumor	☐ Other:

Endocrine (check all that apply)

☐ Hypothyroid	☐ Hypoglycemia	☐ Night Sweats
☐ Hyperthyroid	☐ Diabetes Mellitus	☐ Feeling Hot or Cold