

Date: _____

Internal Arts Acupuncture and Herbal Medicine
77 Turnpike Road
Ipswich, MA, 01938

HEALTH HISTORY QUESTIONNAIRE

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held strictly confidential.* If you have any questions, please ask. If there is anything you wish to bring to my attention that is not included in this form, please note it in the "comments" section on the last page. Thank you.

Name: _____	Date of Birth: _____	Weight: _____
Family Physician: _____		Height: _____
Location: _____		
Marital status: _____	Referred by: _____	
Insurance Company: _____	Policy # _____	

Have you ever been treated by acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Main problem(s) you would like help with:
How long ago did this problem begin? Please be specific:
To what extent does this problem interfere with daily activities such as work, sleep, sex, etc.?
Have you ever been given a diagnosis for this problem? If so, what?
What kinds of treatment have you tried?

PAST MEDICAL HISTORY (please include date):

Significant Illnesses (please circle all applicable)					
Cancer	Diabetes	Hepatitis	High Blood Pressure	Heart Disease	Rheumatic Fever
Thyroid Disease	Seizures	Venereal Disease	Other: _____		
Surgeries					
Significant Trauma (auto accidents, falls, breaks, etc.)					
Allergies (drugs, chemicals, foods)					
Birth History (prolonged delivery, premature, forceps)					

Family Medical History: (Please circle all applicable and note which family member was affected.)					
Cancer	Diabetes	Hepatitis	Heart Disease	High Blood Pressure	
Rheumatic Fever	Thyroid Disease	Seizures	Venereal Disease	Other	

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Medicines taken within the last two months (vitamins, drugs, herbs, etc.)		
Occupation:	Occupational stress (chemical, physical, psychological, etc.)	
Do you have a regular exercise program? If yes, please describe.		
Have you ever been on a restricted diet? If yes, what kind?		
Morning:	Please describe your average daily diet: Afternoon:	Evening:
How many packs of cigarettes do you smoke each day?		
How much coffee, tea or cola do you drink per week?		
Please describe any use of drugs for non-medical purposes.		

Please check if you have had any of the following within the last 3 months:

General		
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Tremors	<input type="checkbox"/> Cravings
<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Poor Balance	<input type="checkbox"/> Change in appetite
<input type="checkbox"/> Bleed or bruise easily	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Peculiar Tastes or smells	<input type="checkbox"/> Strong thirst	
<input type="checkbox"/> Energy drops suddenly (what time of day?)		

Skin and 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"/> Recent moles
<input type="checkbox"/> Change in hair or skin texture? (Explain)		
<input type="checkbox"/> Any other hair or skin problems? (Explain)		

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"/> Dizziness	<input type="checkbox"/> Fainting
<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Swelling of feet
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Any other heart or blood vessel problems?		

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Respiratory

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Difficulty breathing while lying down | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pain upon deep breathing | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Production of phlegm? Color? | |
| <input type="checkbox"/> Any other lung problems? | | |

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 bleeds | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores or lips, tongue |
| <input type="checkbox"/> Other teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches (Where, when) |
| <input type="checkbox"/> Any other head or neck problems? | | |

Gastrointestinal

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Frequent 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 (frequent) | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Chronic use of laxatives | |
| <input type="checkbox"/> Any other problems with your stomach, intestines? | | |

Genito-Urinary

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Blood in urine | |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Wake to urinate? How often? | |
| <input type="checkbox"/> Any other problems with genito-urinary system? | | |

Reproductive and Gynecologic

- | | | |
|--|--|--|
| <input type="checkbox"/> Pregnancies #: | <input type="checkbox"/> Live Births #: | <input type="checkbox"/> Miscarriages #: |
| <input type="checkbox"/> Abortions #: | <input type="checkbox"/> Premature Births #: | <input type="checkbox"/> Age at First Menses: |
| <input type="checkbox"/> Period Btwn Menses | <input type="checkbox"/> Duration of Menses | <input type="checkbox"/> Unusual Character of flow
(heavy, light) |
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Last Pap | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Sores |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Menopause (Age when began?) | |
| <input type="checkbox"/> Changes in Body/Psyche prior to menstruation? Any PMS symptoms? | | |
| <input type="checkbox"/> Do you practice birth control? What type? For how long? | | |

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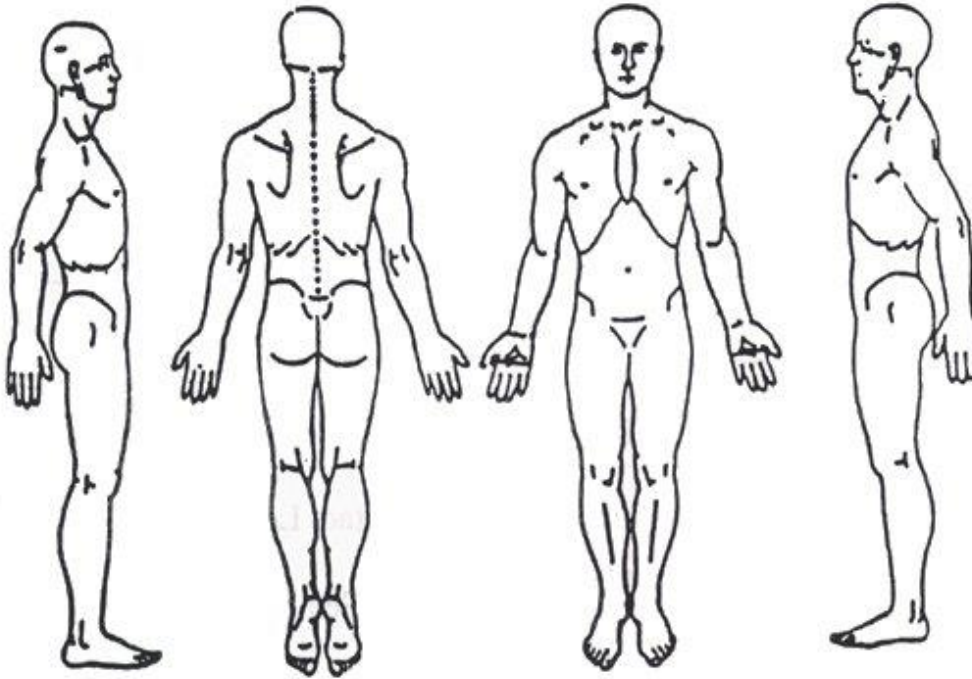
Musculoskeletal (*please note left or right if applicable*)

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain (upper, mid, lower?) | <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"/> Any other joint or bone problems? | | |

Neuro-psychological

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Depression | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> Have you ever been treated for emotional problems? | | |
| <input type="checkbox"/> Any other neurological or psychological problems? | | |

Please indicate any painful or distressed body areas by circling the particular area:



COMMENTS:

Please tell me of any other problems that you would like to discuss.

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Mike Arsenault, MEd., Lic. Ac.
77 Turnpike Rd.
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PATIENT DATA WORKSHEET

Patient's Name: _____

Address: _____

Telephone: _____ (Hm) _____ (Wk)

In case of emergency, please contact:

Name: _____ Phone _____

Relationship: _____

Office Policies

Needles: All needles are one-use, sterile and disposable.

Preparation for Treatment: Please wear or bring loose fitting clothes that allow for your comfort and also exposure of acupoints. If you are needle-shy be sure to eat something 2-3 hours before your treatment.

Cancellations: I make every attempt to keep on schedule to better serve you. Should you need to cancel or reschedule an appointment I ask that you give at least 24 hours notice so another patient can take your appointment. If you miss or cancel your appointment with less than 24 hour notice, you will be charged the normal cost of treatment.

Payment: Payment for your treatment and any herbs received must be paid at the time of your visit. There is a \$10.00 fee for returned checks.

I appreciate the opportunity to work with you. My goal is to help you achieve and maintain balanced health. If you have any questions about these policies or any procedures during treatment, I will make every effort to answer them.

I understand and agree to the office policies stated above.

Signature of patient or guardian

Date