Back Bay Acupuncture
581 Boylston Street, Suite 304
Boston, MA 021116

HEALTH HISTORY QUESTIONNAIRE

Name: _____
First Middle Last

Address: _____
Street Apt City State Zip

Primary Phone: _____ Alternate Phone: _____

Email address: _____ Date of Birth: _____Age: _____

Would you like to receive the monthly newsletter with healthy tips, specials, and updates? YES NO

Occupation:
_____

Who may we thank for referring you?
_____

Primary Care Physician:
_____
Name Phone

Physician Address:
_____

In case of an emergency, please call: _____
Name **Relation**

_____
Street **City** **State** **Zip** **Phone**

Street Suite City State Zip

CHIEF COMPLAINT

Describe your chief complaint or health concern. If your office visit is concerning a specific health condition or illness, please describe your concern in as much detail as possible. Include the first time that you noticed the condition and describe any factors or events you feel are important or that may have played a role in the onset and progression.

Have you received a diagnosis for this condition?

Significant trauma (physical or emotional) /Hospitalizations:

Surgeries (please include date of procedure):

Allergies (chemical, environmental, food, drugs, etc.)

CURRENT MEDICATIONS

Please list all physician prescribed medication, over-the-counter medication, nutritional supplements, vitamins, minerals, herbal or homeopathic remedies that you have taken within the last three months.

NAME	DATE BEGAN	DOSAGE	REASON FOR TAKING
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

HEALTH SCREENING HISTORY

EXAM/TEST	DATE	RESULTS	EXAM/TEST	DATE	RESULTS
Blood Panel			Eye Exam		
Chest X-ray			Mammogram		
Cholesterol			Pap Smear		
Colonoscopy			Prostate Exam		
Complete Physical Exam			PSA		
Other (please specify)			Other (please specify)		

REVIEW OF SYSTEMS

Please indicate all symptoms that you have experienced **IN THE PAST MONTH** by placing an X in the appropriate box.

GENERAL

- ☐ Chills
- ☐ Excessive Sweats
- ☐ Catch colds easily
- ☐ Fever
- ☐ General Body Aches
- ☐ Weight gain
- ☐ Fatigue
- ☐ Weight Loss

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Blurred Vision
- ☐ Concussions
- ☐ Dental Problems
- ☐ Dizziness
- ☐ Dry Eyes
- ☐ Ear Infections
- ☐ Ear Ringing
- ☐ Excessive Tearing
- ☐ Eye Pain
- ☐ Facial Pain
- ☐ Floaters
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Itchy Eyes
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Migraines
- ☐ Mouth Sores
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sneezing
- ☐ Sore Throat

RESPIRATORY

- ☐ Asthma
- ☐ Phlegm, mucous
- ☐ Bronchitis
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath
- ☐ Wheezing

DERMATOLOGY

- ☐ Dry Skin
- ☐ Eczema
- ☐ Hair Loss
- ☐ Itchy Skin
- ☐ Pimples
- ☐ Rash
- ☐ Scars

CARDIOVASCULAR

- ☐ Bleed Easily
- ☐ Bruise Easily
- ☐ Chest Pain/Pressure
- ☐ Cold Hands & Feet
- ☐ Dizziness
- ☐ Edema
- ☐ Fainting
- ☐ Feet/legs Swelling
- ☐ Hand Swelling
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Leg Cramps
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL

- ☐ Abdominal Pain/ Cramping
- ☐ Acid Reflux
- ☐ Belching
- ☐ Blood in the Stool
- ☐ Constipation
- ☐ Decreased Appetite
- ☐ Diarrhea
- ☐ Eating Disorders
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Mucus in Stools
- ☐ Nausea

GENITOURINARY

- ☐ Blood in the urine
- ☐ Burning Urination
- ☐ Cloudy Urine
- ☐ Decreased urination
- ☐ Dribbling
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection
- ☐ Urination at Night

WOMEN'S HEALTH

- ☐ Amenorrhea
- ☐ Bleeding between periods
- ☐ Decreased Sex Drive
- ☐ Hot Flashes/Night sweats
- ☐ Irregular menstrual cycle
- ☐ Menstrual clots
- ☐ Menstrual pain
- ☐ Swelling or pain of breasts
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal itching
- ☐ Vaginal pain

Please indicate the correct number.

_____Age Menstruation Began

_____Number of days cycle lasts

_____Number of days between cycles

_____Date of Last Cycle

_____Age of Menopause

Please list the number of:

_____Births

_____Children

_____C-sections

_____Ectopic Pregnancies

_____Elective Abortions

_____Miscarriages

_____Pregnancies

Are you currently pregnant? (circle one) YES NO

Are you currently trying to conceive? (circle one) YES NO

Are you currently nursing? (circle one) YES NO

MEN'S HEALTH

- ☐ Decreased Sex Drive
- ☐ Genital Itching
- ☐ Genital Pain
- ☐ Impotence
- ☐ Infertility
- ☐ Pain in Testicles
- ☐ Prostate Enlargement
- ☐ Spermatorrhea

NEUROLOGICAL

- ☐ Change in Gait
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Loss of Sensation
- ☐ Numbness
- ☐ Seizures
- ☐ Slow or slurred speech
- ☐ Tremors
- ☐ Vertigo

MUSCULOSKELETAL

Where is the pain located? :

- ☐ Arthritis
- ☐ Difficulty Lifting
- ☐ Difficulty Sitting
- ☐ Difficulty Standing
- ☐ Difficulty Walking
- ☐ Limited Range of Motion
- ☐ Loss of Grip Strength
- ☐ Loss of Sensation
- ☐ Muscle spasm
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Swelling

What is the quality of your pain? Place an X in any box that applies.

- ☐ Achy
- ☐ Burning
- ☐ Cramping
- ☐ Deep
- ☐ Dull
- ☐ Electric
- ☐ Loss of Sensation
- ☐ Numb
- ☐ Pins & Needles
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing

MENTAL HEALTH

- ☐ Anger
- ☐ Anxiety
- ☐ Apathy
- ☐ Depression
- ☐ Difficulty Making Decisions
- ☐ Fear
- ☐ Grief
- ☐ Irritability
- ☐ Lethargy
- ☐ Memory Loss
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Poor Concentration
- ☐ Restlessness
- ☐ Suicidal Thoughts

What are major stress factors in your life?

_____

Are you currently in psychotherapy, counseling or involved in a support group? YES NO

LIFESTYLE
Please indicate any of the following substances that apply to you now or in the past.

Caffeine	Yes	No	_____amount per day/week	
Alcohol	Yes	No	_____amount per day/week	_____age began _____age quit
Tobacco (cigarettes)	Yes	No	_____cigarettes per day/week	_____age began _____age quit

Have you ever been treated for substance abuse? YES NO

NUTRITION

Do you have any other diet restrictions/allergies?

_____

SLEEP

How many hours per night do you sleep? _____

Do you feel rested when you wake up?	YES	NO
Do you have difficulty falling asleep?	YES	NO
Do you have difficulty staying asleep?	YES	NO
Do you dream excessively?	YES	NO
Do you have nightmares?	YES	NO

ENERGY

How would describe your energy: (circle one) excellent good average tired exhausted

Have you experienced any significant change in your energy level? YES NO
If yes, please explain. _____

I have read the above information and certify it to be true to the best of my knowledge and belief and hereby authorize Christina Dea Lic.Ac. to do whatever is necessary, in accordance with state statues, for the care and management of this complaint.

Signature of patient or legal guardian: _____Date: _____