



## Health History

### New England Community Acupuncture

Woburn  
 323 New Boston St.  
 Suite 2  
 Woburn, MA 01801  
 781.933.8088

North Andover  
 733 Turnpike St. (Rt. 114)  
 Jasmine Plaza  
 North Andover, MA 01845  
 978.258.0427

Name:		Contact - Cell:
Street:		Home:
City:		Work:
State:	Zip:	Email:
DOB:	Height:	Occupation:
Age:	Weight:	Physician:
Emergency Contact - Name & Phone Number:		
How did you hear about NECA:		

Main Complaint(s): 1-
2-
3-
How long ago did this begin:
Have you consulted a physician:
Have you been given a diagnosis, if so, what:
What forms of treatment have you tried:
Have you tried acupuncture or Chinese herbal medicine before:

Past Medical History - Please circle all applicable to you:				
Cancer	Diabetes	Hepatitis A, B, C	High Blood Pressure	Heart Disease
HIV	Seizures	Auto Immune	Thyroid Disease	Pace Maker
Depression	IBS	Hysterectomy	Kidney Disease	Prostate Issues
Significant Trauma, auto accidents, injuries:				
Sugeries and Dates:				
Other Significant Illness(es):				

Medications:(include prescription, OTC, vitamins, herbs etc)

Do you currently take a multivitamin or antioxidant? Yes No

**Average Diet**

Morning

Afternoon

Evening

**Daily Health - Habits**

Do you smoke? Yes No - If yes, how much?

How much soda do you drink in a week?

Do you drink Diet beverages?

Is more than 25% of your diet frozen, canned, boxed or processed foods? Yes No

How much water do you drink in a day?

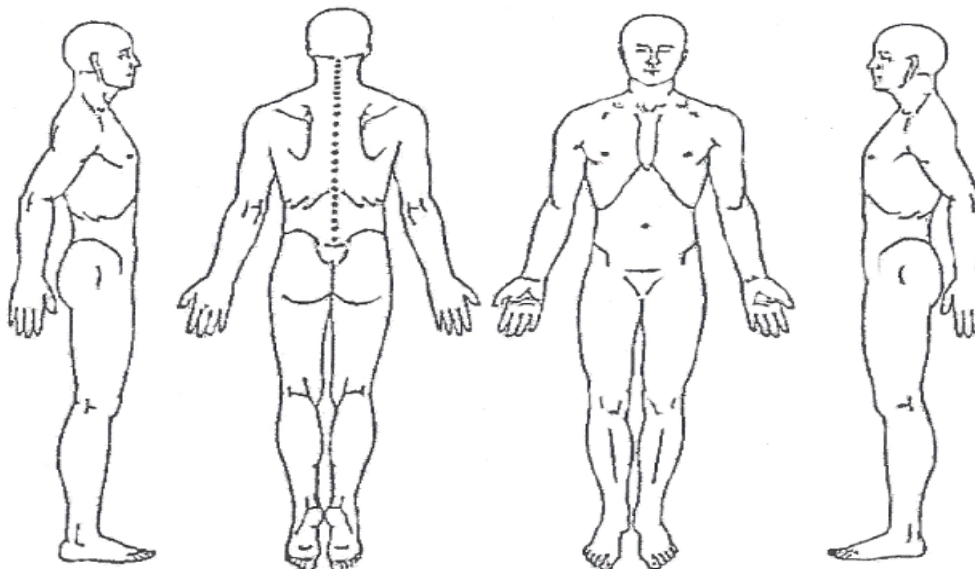
How much coffee do you drink in a day?

How much alcohol do you drink in a week?

Describe how you feel about your appetite - Too Good Just Right Not Good Enough

Average number of hours of sleep per night?

Please indicate areas of pain



**General**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Fevers       | <input type="checkbox"/> Strange Tastes or Smells | <input type="checkbox"/> Poor Sleep         |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Cravings                 | <input type="checkbox"/> Fatigue            |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Change in Appetite       | <input type="checkbox"/> Sudden Energy Drop |
| <input type="checkbox"/> Running Warm | <input type="checkbox"/> Weight Loss              | <input type="checkbox"/> Cold Hands Feet    |
| <input type="checkbox"/> Running Cold | <input type="checkbox"/> Weight Gain              | <input type="checkbox"/> Strong Thirst      |

**Skin and Hair**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Rashes        | <input type="checkbox"/> Ulcerations   | <input type="checkbox"/> Hives         |
| <input type="checkbox"/> Itching       | <input type="checkbox"/> Oozing Ulcers | <input type="checkbox"/> Recent Moles  |
| <input type="checkbox"/> Dandruff      | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Discoloration |
| <input type="checkbox"/> Dry Skin      | <input type="checkbox"/> Psoriasis     | <input type="checkbox"/> Infection     |
| <input type="checkbox"/> Brittle Nails | <input type="checkbox"/> Hair Loss     | <input type="checkbox"/> Other:        |

**Head**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Poor Vision              | <input type="checkbox"/> Migraines         |
| <input type="checkbox"/> Vertigo                   | <input type="checkbox"/> Eye Tenderness           | <input type="checkbox"/> Tension Headaches |
| <input type="checkbox"/> Ringing in Ears           | <input type="checkbox"/> Eye Twitching            | <input type="checkbox"/> Sinus Congestion  |
| <input type="checkbox"/> Ear Blockage              | <input type="checkbox"/> Eye Tearing              | <input type="checkbox"/> Sore Throats      |
| <input type="checkbox"/> Facial Pain               | <input type="checkbox"/> Dry Eyes                 | <input type="checkbox"/> Post Nasal Drip   |
| <input type="checkbox"/> Teeth Grinding            | <input type="checkbox"/> Spots/Floaters in Vision | <input type="checkbox"/> Nose Bleeds       |
| <input type="checkbox"/> TMJ                       | <input type="checkbox"/> Poor Night vision        | <input type="checkbox"/> Cloudy Fogginess  |
| <input type="checkbox"/> Cankersores - Mouth Ulcer | <input type="checkbox"/> Cataracts                | <input type="checkbox"/> Concussion        |

**Cardiovascular**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chest Pain/Tightness      | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Blood Clots               |
| <input type="checkbox"/> Irregular Heartbeat       | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Swelling in Limbs  | <input type="checkbox"/> Varicose Veins            |

**Respiratory**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Production of Phlegm |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Wheezing             | <input type="checkbox"/> Short of Breath      |

**Gastrointestinal**

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Nausea      | <input type="checkbox"/> Gas            | <input type="checkbox"/> Abdominal Pain - Cramps  |
| <input type="checkbox"/> Vomiting    | <input type="checkbox"/> Belching       | <input type="checkbox"/> Rectal Pain - Burning    |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Blood in Stool           |
| <input type="checkbox"/> Bloating    | <input type="checkbox"/> Sluggish Bowel | <input type="checkbox"/> Undigested Food in Stool |
| <input type="checkbox"/> Other:      |   |   |

**Urinary**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Frequent Urination  | <input type="checkbox"/> Pain Upon Urination  | <input type="checkbox"/> Inability to Empty Bladder |
| <input type="checkbox"/> Urgency to Urinate  | <input type="checkbox"/> Blood in Urine       | <input type="checkbox"/> Weak Stream                |
| <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Frequent UTIs        | <input type="checkbox"/> Kidney Stones              |
| <input type="checkbox"/> Dark Color to Urine | <input type="checkbox"/> Strong Odor to Urine | <input type="checkbox"/> Frequent Night Urination   |

**Male Health**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Impotence             | <input type="checkbox"/> Low Sperm Count | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Low Motility    | <input type="checkbox"/> STDs       |
| <input type="checkbox"/> Enlarged Prostate     | <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Other:     |

**Female Health**

Are you or is it possible that you're pregnant:

# of Live Births:

# of Miscarriages:

Age of first period:

Days between Day 1 of period:

Using Birth Control:

Duration of Period:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heavy Period                | <input type="checkbox"/> Uterine Fibroids    | <input type="checkbox"/> Vaginal Discharge         |
| <input type="checkbox"/> Light/Scanty Period         | <input type="checkbox"/> Ovarian Cysts       | <input type="checkbox"/> Frequent Yeast Infections |
| <input type="checkbox"/> Painful Period              | <input type="checkbox"/> Endometriosis       | <input type="checkbox"/> STDs                      |
| <input type="checkbox"/> Breast Tenderness           | <input type="checkbox"/> Clots in Blood Flow | <input type="checkbox"/> Infertility Issues        |
| <input type="checkbox"/> Period begins with spotting | <input type="checkbox"/> PMS                 | <input type="checkbox"/> Spotting During Ovulation |

**Musculoskeletal**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Hand / Wrist Pain | <input type="checkbox"/> Overall Muscle Achiness |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Foot / Ankle Pain | <input type="checkbox"/> Muscle Weakness         |
| <input type="checkbox"/> Back Pain     | <input type="checkbox"/> Hip Pain          | <input type="checkbox"/> Herniated Discs         |
| <input type="checkbox"/> Sciatica      | <input type="checkbox"/> Knee Pain         | <input type="checkbox"/> Other:                  |

**Neurological**

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Areas of Numbness       |
| <input type="checkbox"/> Stroke     | <input type="checkbox"/> Loss of Balance     | <input type="checkbox"/> Tremors                 |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Confusion           | <input type="checkbox"/> Neuropathy - Nerve Pain |
| <input type="checkbox"/> Other:     |  |  |

**Emotions**

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Insomnia - mind racing | <input type="checkbox"/> Panic Attacks     |
| <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Fearful                | <input type="checkbox"/> Cloudy Foggy Mind |
| <input type="checkbox"/> Anger      | <input type="checkbox"/> Phobias                | <input type="checkbox"/> Other:            |

Are you currently being treated for emotional or psychological issues:

Have you ever considered or attempted suicide?

## CONSENT TO TREATMENT

I, \_\_\_\_\_, hereby authorize the acupuncturist's of New England Community Acupuncture, Inc. to administer treatment of acupuncture, adjunctive techniques and herbal medicine relevant to my diagnosis. The patient has the right to refuse any form of 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 strongly recommended. Treatment may include but is not limited to the following:

1. Insertion of various styles 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 of gua sha. This technique may cause redness on the skin at the sight of treatment. Slight bruising and tenderness may persist after the treatment.
4. The placement of suction cups on the skin. These cups may produce a red or purple mark on the skin at the sight of the cup. Slight bruising or tenderness may persist after the treatment.
5. Electrical stimulation of the needles may be used producing a tapping sensation at the needle location.
6. Herbal medicine, administered in various forms including tablets, capsules, extract powders, raw herbs and liniments. These herbs are taken orally and/or topically. Some patients may experience side effects including but not limited to upset stomach or nausea.

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 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.

Signature of Patient or Legal Guardian:

\_\_\_\_\_

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

Dear Valued Patients:

NECA treats a large patient base and sometimes needs to turn patients away because our schedule is full. In order for us to provide affordable care we are largely dependent upon you keeping your scheduled appointment.

We ask that you please be sensitive to our mission, the needs of our clinic, and the time of our professional staff.

**All appointments that are cancelled with less than 24 hours notice, or are missed altogether without letting our front desk know, will be charged a \$10.00 fee payable at the next visit.**

We do recognize that real emergencies happen, and would be happy to consider these on an individual basis. Thanks for understanding and in doing so, helping us to keep our fees as low as possible.

We appreciate your business.

Thank you. The NECA Family 😊

Signature

---