Blake Acupuncture & Herbal Medicine

16 Bradlee Road, Medford, MA 02155 781-269-2849
www.MedfordSquareAcupuncture.Com

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential*. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. Thank you.

Date

Name (First & Last)	Home phone	Work phone
Street	City	State/Zip
Date of Birth	Age	Height / Weight
Occupation	Family Physician	Referred By
Emergency Contact - Name (First & Last)	Emergency Contact - Phone	Relation to you

Have you been treated by acupuncture or Oriental medicine before? ☐Yes ☐No
Main problem(s) you would like us to help you with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, such as work, sleep, and sex?
Have you been given a diagnosis for this problem? If so, what?
What other 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 (please specify):

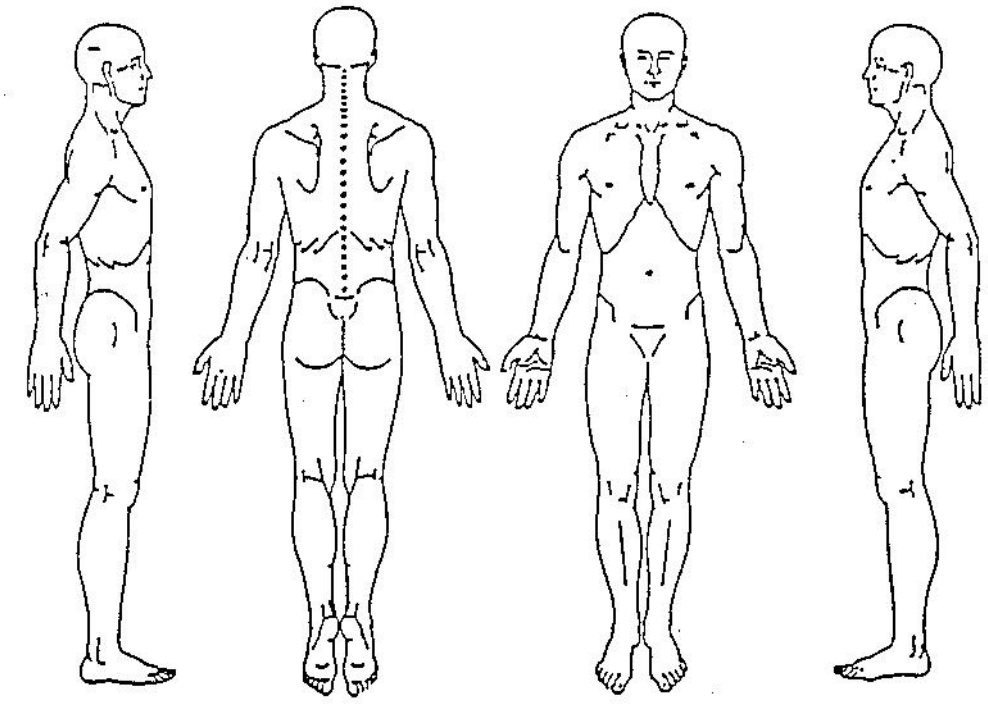
Surgeries
Significant trauma (auto accidents, falls, etc.)
Allergies (drugs, chemicals, foods)

Family Medical History*(please circle all applicable)*

Asthma	Allergies	Diabetes	Cancer	Heart Disease	High Blood Pressure
Stroke	Seizures	Thyroid	Other (please specify):		

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)		
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?		
Please describe your average daily diet:		
Morning:	Afternoon:	Evening:
Do you smoke? If yes, how much?		
How much caffeinated coffee, tea, or cola do you drink per week?		
How much water do you drink per day?	How much alcohol do you drink?	
Please describe any use of drugs for non-medical purposes.		

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



Name: _____ Date: _____

Please check if you have had (in the last three months):

General

- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Chills
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Strong thirst (hot or cold drinks)
- ☐ Poor sleeping
- ☐ Fatigue
- ☐ Sudden energy drop (time of day?)

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems?
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Any other head or neck problems?
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches (where, when?)

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Any other heart or blood vessel problems?
- ☐ Low blood pressure
- ☐ Swelling of feet
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Varicose veins
- ☐ Stroke

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Production of phlegm. What color?
- ☐ Any other lung/breathing problems?
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ Wheezing while breathing
- ☐ Difficulty in breathing when lying down
- ☐ Shortness of breath
- ☐ Pain with a deep breath

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Any other problems with your stomach or intestines?
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Abdominal pain or cramps
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Chronic laxative use

Genito-Urinary

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Pain upon urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Kidney stones
- ☐ Any particular color to your urine:
- ☐ Do you wake up to urinate? How often?
- ☐ Any other problems with your genital or urinary system?

Male Reproductive

- ☐ Impotency
- ☐ Premature Ejaculation
- ☐ Spermatorrhea
- ☐ STDs
- ☐ Prostatitis
- ☐ Prostate Cancer
- ☐ Benign Prostatic Hypertrophy
- ☐ Testicular pain/injury
- ☐ Testicular Cancer
- ☐ Sores on genitals
- ☐ Any other reproductive problems?

Female Reproductive and gynecologic

Are you pregnant? Yes No

Is it possible that you are pregnant? Yes No

- ☐ Pregnancies #: _____
- ☐ Abortions #: _____
- ☐ Time between menses: ____
- ☐ Irregular periods
- ☐ Last PAP
- ☐ Breast lumps
- ☐ Live births #: _____
- ☐ Premature births #:_____
- ☐ Duration of menses: ____
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Menopause Age: _____
- ☐ Miscarriages #: _____
- ☐ Age of first menses: _____
- ☐ Unusual character (heavy, light)
- ☐ Clots
- ☐ Vaginal sores
- ☐ STDs
- ☐ Changes in body/psyche prior to menstruation
- ☐ Do you practice birth control? What type and for how long?
- ☐ Any other reproductive problems?

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Hip pain
- ☐ Any other joint or bone problems?

Neuropsychological

- ☐ Seizures
- ☐ Stroke
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Areas of numbness
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of Balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Lack of coordination

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

- ☐ Any other neurological or psychological problems?

COMMENTS: *Please briefly tell us of any other problems you would like to discuss.*

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Lisa M Blake, Lic.Ac.

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above- named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name _____

Patient's/Patient Representative's Signature _____

Today's Date _____/_____/_____

Office Policies

The following policies and procedures are in place to ensure that your care is as efficient and effective as possible.

APPOINTMENTS: We make every effort to remain on schedule. We believe that respect between patient and practitioner includes respect for each other's time. If you are late, your remaining time may not be sufficient for a full treatment, so treatment will be tailored to fit within the time available or you have the option to reschedule.

Occasionally, there are situations that arise that cause us to run over. If we are late, it will not affect the time of your treatment. If you have time constraints, please let us know.

It is recommended that you wear loose fitting clothing to appointments for your comfort and to make acupuncture points accessible. You may bring a pair of shorts or loose undershirt to change into.

CANCELLATION/LATE ARRIVAL POLICY: Your appointment time is reserved solely for you, consequently, a **24-hour cancellation policy** applies to your appointment. You may leave a message on our voice mail system at any time of day to cancel your appointment, and it will date and time stamp your call. If you are unable to cancel your appointment 24-hours in advance, a cancellation charge for the **full treatment fee** will apply. (If you must cancel due to an emergency, please explain to the clinic.)

Please do your best to arrive on time for your appointment. If you find that you are running late, please call the clinic to let your practitioner know and we will do our best to accommodate you, depending on schedule availability.

CONFIDENTIALITY: All information gathered within the context of treatment is held in strict confidence and will NOT be released without your written consent. However, if your insurance is covering your treatments, they have the right to request copies of all records pertaining to your treatment.

PAYMENT: Payment is expected at the time of the visit unless other arrangements have been made in advance. We accept cash, check, credit cards and flex spend cards.

Acupuncture is covered by some private insurance policies. Should you have coverage, we can discuss the procedure for billing and payment. *We do not accept worker's compensation or personal injury cases.*

I have read and agree to the policies outlined above.

Signature of Patient:

Date: