

Body Wellness Center
118 Main Street, 2nd floor • Sturbridge, MA 01566 • 508-347-7494

Health History

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 on this form, please not in the comments section. Thank you.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Marital Status: _____ Date of Birth: _____ Age: _____

Physician: _____ Phone: _____

In Emergency Notify: _____ Phone: _____

Referred By: _____ Occupation: _____

Have you been treated by acupuncture of Oriental medicine before? _____

Main Complaint (symptoms, diagnosis, duration, etc.) _____

What kinds of treatments have you tried? _____

Significant Trauma (physical or emotional) _____

Allergies (chemicals, foods, drugs, etc.) _____

Medications (please attach additional pages if necessary) _____

Surgeries (please include date of procedure)_____

Your Birth History (prolonged labor, forceps delivery, etc.)_____

Exercise (type of activity, days per week, length of workout)_____

Diet (meals per day, caffeinated drinks, alcohol per week)_____

Personal Medical History – Please check any conditions or symptoms you have now.

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other_____ |

Family Medical History – Please check any condition that applies to your immediate family.

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other_____ |

General – Please check if you have had any of these items listed below within the last 3 months.

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Sudden Energy Drop | <input type="checkbox"/> Bleed/Bruise Easily | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Strong Thirst (hot or cold) |

Skin and Hair

- | | | |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Eczema | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Change in skin/hair texture |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Skin Discoloration |

Head, Eyes, Ears, Nose and Throat

- | | | |
|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Spots in Front of Eyes | <input type="checkbox"/> Glasses | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Jaw Clicks | <input type="checkbox"/> Sores on Lips/Tongue |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Recurrent Sore Throats | <input type="checkbox"/> Difficulty Swallowing |

Cardiovascular

- | | | |
|---|---|--|
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain or Pressure | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Varicose/Spider Veins |
| <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Spontaneous Sweating |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Phlebitis |

Respiratory

- | | | |
|--|---|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficult Breathing |
| <input type="checkbox"/> Pain with Deep Inhalation | <input type="checkbox"/> Production of Phlegm...if so what color? _____ | |

Gastrointestinal

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Chronic Laxative Use |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> IBS/Crohn's Disease | <input type="checkbox"/> Abdominal Pain/Cramps |

Genito-Urinary

- | | | |
|--|---|---|
| <input type="checkbox"/> Pain upon Urination | <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Decrease in Flow |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Sore on Genitals |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Impotence |

Genito-Urinary (continued)

- Decreased Libido
- Herpes
- Urinary Tract Infection
- Prostatitis
- Dribbling after Urination
- Night Urination

Gynecological/Reproductive

- Painful Periods
- Irregular Menstruation
- Endometriosis
- Vaginal Sores
- Polycystic Ovarian Disease
- Fibrocystic Breast Tissue
- Vaginal Discharge
- Ovarian Cysts
- Infertility
- Vaginal Dryness
- Uterine Fibroids
- Number of Abortions_____
- Age of first Menses_____
- Date of last Menses_____
- Date of last PAP_____
- Number of Pregnancies_____
- Number of live Births_____
- Number of Miscarriages_____

Musculoskeletal

- Back Pain
- Hip Pain
- Bursitis
- Hand/Wrist Pain
- Carpal Tunnel
- Knee Pain
- Shoulder Pain
- Sprains/Strains
- Foot/Ankle Pain
- Rotator Cuff
- Neck Pain
- Sciatica
- Muscle Pain
- Tendonitis
- Muscle Weakness

Neuropsychological

- Seizures
- Anxiety/Panic Attacks
- Depression
- ADD/ADHD
- Concussion
- Vertigo/Dizziness
- Loss of Balance
- Poor Memory
- Nervousness
- Easily Susceptible to Stress
- Lack of Coordination
- Areas of Numbness
- Bad Temper/Irritability
- Manic Depression

Have you even been treated for emotional problems?_____

Have you ever considered or attempted suicide?_____

Have you ever been treated for substance abuse?_____

Comments, please inform us of any other problems you would like to discuss._____

