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**617.913.5970 fax: 866.709.1684**

### Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Although you may feel many questions do not pertain to your health concerns it is important that you answer them to your best ability. They are important in us working together to achieve your health goals. All of your answers are held absolutely confidential.

Date:					
Name (First & Last)		Home Phone (    )    -		Work/Cell Phone (    )    -	
Street		City		State/Zip	
Email		Date of Birth	Age	Height	Weight
Occupation		Family Physician		Referred By	
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> In Partnership	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	
Emergency Contact (Name & Relation to you)			Emergency Phone(    )    -		
What is the main problem(s) you'd like me to help you with? 1. 2. 3. 4. 5.					
How long ago did this problem begin?					
To what extent does this problem interfere with your daily activities such as work, sleep, sex?					
Have you been given a diagnosis for this problem? If so, what?					
What other kinds of treatments have you tried?					

### Medical History:

Check all conditions you've had in the past or currently have:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> CVA (stroke)          | <input type="checkbox"/> Vein condition  | <input type="checkbox"/> Thyroid disorder    |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Gonorrhea             | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Bleeding tendency   |
| <input type="checkbox"/> Syphilis             | <input type="checkbox"/> Measles               | <input type="checkbox"/> Chicken pox     | <input type="checkbox"/> Nervous disorder    |
| <input type="checkbox"/> Meningitis           | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Polio           | <input type="checkbox"/> Mononucleosis       |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> High fever            | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Paralysis            | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Migraines       | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> other lung illnesses | <input type="checkbox"/> other liver illnesses | <input type="checkbox"/> Gallstones      | <input type="checkbox"/> Kidney Stones       |
| <input type="checkbox"/> other: _____         |  |  |  |

Have you ever been on long term or frequent antibiotic therapy?  Yes (when, how long)  No

Surgeries (type and date)

Significant Trauma (auto accidents, falls, abuse etc)

Significant Dental Work (type and date)

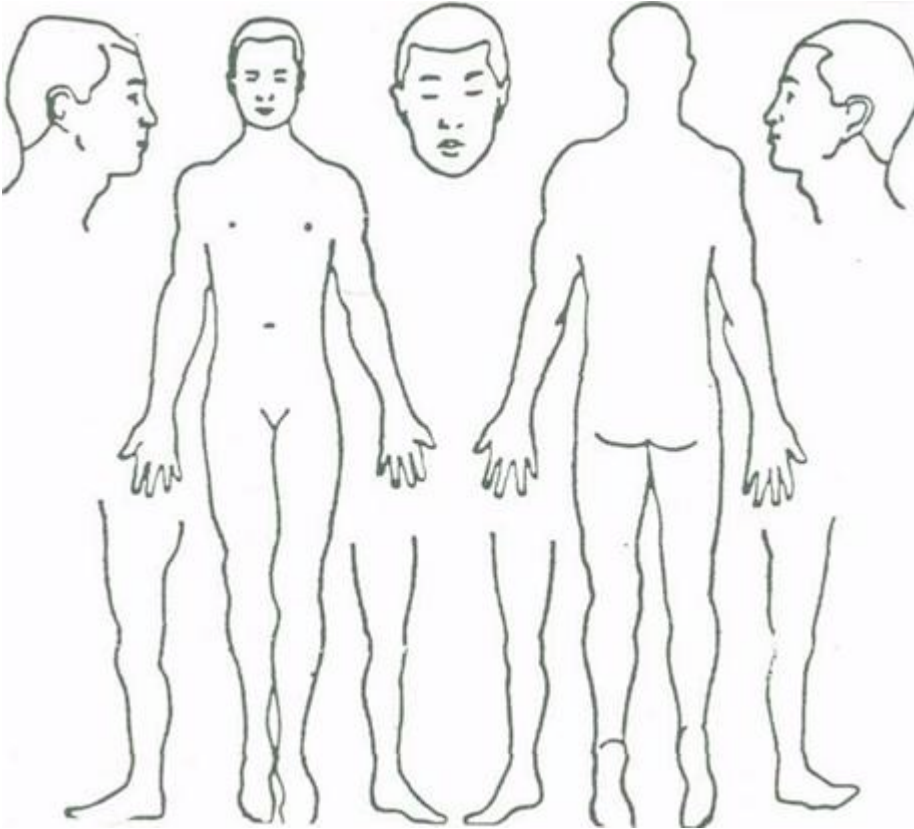
Allergies (pollen, dander, drugs, synthetic chemicals, foods)

Family Medical History (check and include relation to you)

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer(type)  | <input type="checkbox"/> Other               |



Indicate Painful or Distressed Areas



Please add any additional comments about musculoskeletal issues:

**Women only GYN**

Regular menstrual cycle?  No  Yes  
 Number of children: \_\_\_\_\_  
 Age of first menstruation: \_\_\_\_\_  
 Average number of days of flow: \_\_\_\_\_  
 Vaginal discharge  
 color \_\_\_\_\_

Pregnant?  No  Yes  
 Number of pregnancies: \_\_\_\_\_  
 Age of menopause (if applicable): \_\_\_\_\_  
 Average number of days of entire cycle: \_\_\_\_\_  
 Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> nausea        | <input type="checkbox"/> vomiting     | <input type="checkbox"/> water retention | <input type="checkbox"/> breast swelling   |
| <input type="checkbox"/> food cravings | <input type="checkbox"/> headaches    | <input type="checkbox"/> migraines       | <input type="checkbox"/> breast tenderness |
| <input type="checkbox"/> depression    | <input type="checkbox"/> irritability | <input type="checkbox"/> anxiety         | <input type="checkbox"/> other             |
- emotions: \_\_\_\_\_  
 dull pain, where? \_\_\_\_\_  sharp pain, where? \_\_\_\_\_

Please fill in the following menstrual chart. If you are menopausal please fill in best to your recollection.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Headaches/Migraines (check if yes)							
Other							

**Men only**

- |  |   |                                    |  |
|--|---|------------------------------------|--|
| <input type="checkbox"/> Swollen testes  | <input type="checkbox"/> Testicular pain  | <input type="checkbox"/> Impotence | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Feeling of coldness or numbness in external genitalia | <input type="checkbox"/> Swollen Prostate |                                    |  |
| <input type="checkbox"/> Other _____   |   |                                    |  |

## 24-Hour Cancellation Policy

Your appointment time is reserved specifically for you.

If you are, for any reason, unable to keep your appointment, you must call the office at 617-913-5970, at least **24 hours prior** to your scheduled appointment time to **avoid any charges**. **Partial or full payment is expected for any appointments cancelled within 24 hours of your scheduled appointment** as outlined below:

- Acupuncture cancellation less than 8 hours before appointment will be charged 100% of fee.
- All no-shows will be charged full fee.
- Acupuncture cancellation greater than 8 hours but less than 24 hours before appointment = 60% of fee (i.e. \$45 for a \$75 appointment booking)
- Nutrition cancellation less than 24 hours = Full fee of booked time. (\$30 per 15 minutes)

Of course valid emergencies may occur, and if they do you will not be charged. I want to be reasonable and this isn't about taking your money. It is about keeping our commitment to your healing path and respecting my time. If you have concerns about the policy or making certain appointments please discuss it with me before booking your appointment.

Thank you for your understanding and respect.

**Please read and sign the statement below indicating that you fully agree to this cancellation policy.**

**"I agree to give a minimum of 24 hours notice in cancellation of an appointment. I agree to pay a partial or full charge of the office visit as outlined above if 24 hour notice was not provided."**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_