

# Health History Questionnaire

Please take the time to fill out this questionnaire completely and carefully to help us provide you with a complete health evaluation. We realize that some questions may seem irrelevant to your main problem, but they are significant in helping us to make an accurate diagnosis and formulate an appropriate treatment plan. All your answers are absolutely confidential. If you have any questions, please ask. Thank you.  
**If you need more room, please use the other side of these sheets.**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Street \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

(please circle which number you would prefer we contact you)

Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Email \_\_\_\_\_

Primary Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Referred by \_\_\_\_\_

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

Have you received acupuncture or Oriental medicine before?    yes / no

What is your main complaint?

When did this problem first begin?

How often does this bother you?

Severity of the problem on a scale of 0-10 (0 = best; 10 = worst)

When problem is at its best:        /10            When problem is at its worst:        /10            Today:            /10

If there is pain involved, what is the quality of the pain? (Circle all that apply)

Dull   Achy   Burning   Sharp   Stabbing   Cold   Numb   Tingling   Throbbing   Other \_\_\_\_\_

What makes the problem feel better? (Circle all that apply)

Heat   Cold   Damp weather   Wind   Rest   Work   Movement   Sitting   Lying   Massage/Pressure   Stress

Other \_\_\_\_\_

What makes the problem feel worse? (Circle all that apply)

Heat   Cold   Damp weather   Wind   Rest   Work   Movement   Sitting   Lying   Massage/Pressure   Stress

Other \_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc)?

Have you been given a diagnosis for this problem? yes / no    If so, what?

What kinds of treatment have you tried?

## Turning Leaf Acupuncture

1330 Beacon Street, Suite 223, Brookline, MA 02446 ❖ 1 West Foster Street, 3<sup>rd</sup> Floor, Melrose, MA 02176

619.315.5791

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Significant Trauma (physical or emotional)

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Surgeries (please include date of procedure)

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

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Medications (names & dosages) Please attach an additional page if necessary.

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Vitamins/Supplements/Herbs

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Exercise

Days per week	Length of workout	Type of Activity
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Diet	Snacks	Caffeinated Drinks	Alcohol per week
Meals per day			

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**Personal History** Please check any conditions or symptoms you have now or have had in the past.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease         |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia         | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Elevated Cholesterol  |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS    |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease     |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Gastritis/Pancreatitis  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema             |
| <input type="checkbox"/> Bleeding Tendency       | <input type="checkbox"/> Migraines                  | <input type="checkbox"/> Nervous Disorders          | <input type="checkbox"/> STD (which? _____)    |
| <input type="checkbox"/> Meningitis              | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Syphilis              |

**Family Medical History** Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

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

**Please check the following that pertain to you:****Overall Temperature:**

- |   |  |                                       |   |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Hot body temperature or sensation  | <input type="checkbox"/> Cold hands                      | <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Afternoon flushes    |
| <input type="checkbox"/> Cold body temperature or sensation | <input type="checkbox"/> Cold Feet                       | <input type="checkbox"/> Sweaty feet  | <input type="checkbox"/> Night sweats         |
| <input type="checkbox"/> Heat in the hands, feet and chest  | <input type="checkbox"/> Hot flashes any time of day     |                                       | <input type="checkbox"/> Lack of perspiration |
| <input type="checkbox"/> Perspire easily                    | <input type="checkbox"/> Thirsty: for hot or cold drinks |                                       |   |

**Overall Energy:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Difficulty keeping eyes open during the day | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> General weakness          |
| <input type="checkbox"/> Easily catch colds                          | <input type="checkbox"/> Low energy          | <input type="checkbox"/> Feel worse after exercise |

**Heart:**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Cardiovascular disease                         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Chest pain              |
| <input type="checkbox"/> Fainting                                       | <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Sores on tip of tongue | <input type="checkbox"/> Restlessness            |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Hard to fall asleep | <input type="checkbox"/> Wake unrested          | <input type="checkbox"/> Nightmares              |
| <input type="checkbox"/> Restless Sleep                                 | <input type="checkbox"/> Mental confusion    | <input type="checkbox"/> Restless dreaming      | <input type="checkbox"/> Waking during the night |
| <input type="checkbox"/> Chest pain traveling to shoulders or down arms |  |   |  |

**Lung:**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Profuse nasal discharge:     | thing/clear/runny                                 | thick/white                               | thick/yellow   |  |
| <input type="checkbox"/> Cough: Wet or Dry            | <input type="checkbox"/> Nose bleeds              | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Dry mouth                       |  |
| <input type="checkbox"/> Dry, itchy throat            | <input type="checkbox"/> Sore throat              | <input type="checkbox"/> Dry skin         | <input type="checkbox"/> Allergies: to what?             |  |
| <input type="checkbox"/> Sneezing                     | <input type="checkbox"/> Hives                    | <input type="checkbox"/> Stiff neck       | <input type="checkbox"/> Stiff shoulders                 |  |
| <input type="checkbox"/> Bronchitis                   | <input type="checkbox"/> Rashes                   | <input type="checkbox"/> Itching          | <input type="checkbox"/> Eczema                          |  |
| <input type="checkbox"/> Dandruff                     | <input type="checkbox"/> Sadness                  | <input type="checkbox"/> Melancholy       | <input type="checkbox"/> Smoke cigarettes                |  |
| <input type="checkbox"/> Alternating fever and chills | <input type="checkbox"/> Achy feeling in the body |   | <input type="checkbox"/> Difficulty inhaling or exhaling |  |

**Spleen/Stomach:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Low appetite                           | <input type="checkbox"/> Changes in appetite              | <input type="checkbox"/> Cravings: for what?                              | <input type="checkbox"/> Abrupt weight gain    |
| <input type="checkbox"/> Abrupt weight loss                     | <input type="checkbox"/> Abdominal bloating               | <input type="checkbox"/> Abdominal gas                                    | <input type="checkbox"/> Stomach gurgling      |
| <input type="checkbox"/> Fatigue after eating                   | <input type="checkbox"/> Easily bruised                   | <input type="checkbox"/> Hemorrhoids                                      | <input type="checkbox"/> Pensive/Over-thinking |
| <input type="checkbox"/> Worry                                  | <input type="checkbox"/> Prolapsed organs: which organ(s) |   |  |
| <input type="checkbox"/> Loose stools                           | <input type="checkbox"/> Constipation                     | <input type="checkbox"/> Incomplete bowel movements                       |  |
| <input type="checkbox"/> Diarrhea                               | <input type="checkbox"/> Blood in stool                   | <input type="checkbox"/> Undigested food in stool                         |  |
| <input type="checkbox"/> Mucus in stool                         | <input type="checkbox"/> Black or tarry stool             | <input type="checkbox"/> Chronic use of laxatives: what type of laxative? |  |
| <input type="checkbox"/> General sensation of heaviness in body | <input type="checkbox"/> Mental heaviness                 | <input type="checkbox"/> Mental sluggishness                              |  |
| <input type="checkbox"/> Mental fogginess                       | <input type="checkbox"/> Swollen hands                    | <input type="checkbox"/> Swollen feet                                     | <input type="checkbox"/> Swollen joints        |
| <input type="checkbox"/> Chest congestion                       | <input type="checkbox"/> Nausea                           | <input type="checkbox"/> Snoring  | <input type="checkbox"/> Dizziness             |
| <input type="checkbox"/> Phlegm production                      | <input type="checkbox"/> Burning Sensation after eating   | <input type="checkbox"/> Large appetite                                   | <input type="checkbox"/> Bad breath            |
| <input type="checkbox"/> Vomiting                               | <input type="checkbox"/> Sores on lips, tongue or mouth   | <input type="checkbox"/> Ulcer (if diagnosed)                             | <input type="checkbox"/> Belching              |
| <input type="checkbox"/> Acid regurgitation                     | <input type="checkbox"/> Cold sensation in stomach        | <input type="checkbox"/> Hiccoughs  | <input type="checkbox"/> Stomach pain          |
| <input type="checkbox"/> Bleeding, swollen, or painful gums     |   |   |  |

**Liver and Gallbladder**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Chest pains   | <input type="checkbox"/> Tight sensation in chest              | Bitter taste in mouth   | <input type="checkbox"/> Anger easily     |
| <input type="checkbox"/> Frustration   | <input type="checkbox"/> Depression                            | <input type="checkbox"/> Irritability                                   | <input type="checkbox"/> Skin rashes      |
| <input type="checkbox"/> Tingling sensations   | <input type="checkbox"/> Numbness                              | <input type="checkbox"/> Muscle spasms                                  | <input type="checkbox"/> Muscle twitching |
| <input type="checkbox"/> Muscle cramping   | <input type="checkbox"/> Seizures                              | <input type="checkbox"/> Convulsions                                    | <input type="checkbox"/> Lump in throat   |
| <input type="checkbox"/> Teeth grinding  | <input type="checkbox"/> Alternating diarrhea and constipation | <input type="checkbox"/> Neck tension                                   | <input type="checkbox"/> Shoulder tension |
| <input type="checkbox"/> Hip pain/sciatica   | <input type="checkbox"/> High pitched ringing in ears          | <input type="checkbox"/> Gallstones                                     |   |
| <input type="checkbox"/> Drink alcohol: how much per week?   |  | <input type="checkbox"/> Recreational Drugs: which, how often per week? |   |
| <input type="checkbox"/> Sexually transmitted diseases: which?   |  | <input type="checkbox"/> Genital sores                                  |   |
| <input type="checkbox"/> Frequently unable to adapt to stress (what causes this stress?)                             |  |   |   |
| <input type="checkbox"/> Headaches: How often? Describe location and sensation (dull pressure, throbbing, stabbing): |  |   |   |
| <input type="checkbox"/> Migraines   |  |   |   |

**Eyes:**

- |                                       |  |   |   |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Itchy        | <input type="checkbox"/> Red or bloodshot        | <input type="checkbox"/> Hot            | <input type="checkbox"/> Dry                          |
| <input type="checkbox"/> Watery       | <input type="checkbox"/> Gritty or sandy feeling | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Decreased night vision       |
| <input type="checkbox"/> Near-sighted | <input type="checkbox"/> Far-sighted             | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> Visual Disturbances/Floaters |

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**Kidney:**

- Frequent cavities
- Painful knees
- Memory problems
- Kidney stones
- Foot or ankle weakness or pain
- Easily broken bones
- Weak knees
- Excessive hair loss
- Bladder infections
- Poor hearing
- Cold in knees
- Pre-mature gray hair
- Fearful
- Lack of bladder control
- Earaches
- Low back pain
- Low-pitched ringing in ears
- Easily startled
- Incontinence with sneezing or jumping

How many times per day do you urinate?

Do you wake during the night to urinate?

- Pale yellow
- Cloudy
- Burning
- Dark yellow
- Scanty
- Painful

How many times per night?

- Clear
- Profuse
- Difficult
- Reddish
- Strong odor
- Urgent

**Libido:**

- Normal
- High
- Low

**Men only:**

- Swollen testes
- Sperm abnormalities (morphology, count, etc.?)
- Testicular pain
- Impotence
- Premature Ejaculation
- Other: \_\_\_\_\_

**Women Only:**

- Difficult/Painful intercourse
- Vaginal dryness/itching
- Vaginal sores
- Vaginal discharge(color/amount/odor\_\_\_\_\_)
- Polycystic Ovarian Disease
- Infertility
- Number of pregnancies\_\_\_\_\_
- Number of miscarriages\_\_\_\_\_
- Ovarian cysts
- Endometriosis
- Uterine Fibroids
- Fibrocystic breast tissue
- Number of live births\_\_\_\_\_
- Age of first menses\_\_\_\_\_
- Date of last menses\_\_\_\_\_
- Date of last PAP/Pelvic\_\_\_\_\_
- Painful menstruation
- Irregular menstruation
- PMS
- Number of ectopic pregnancies\_\_\_\_\_

Do you practice birth control?\_\_\_\_\_ What type?\_\_\_\_\_ How long?\_\_\_\_\_

<b>Please fill in the following menstrual chart:</b>	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 (describe size: large, small, black, purple, red, other)							
Vomiting/nausea (check if yes)							
PMS (what symptoms, duration of symptoms)							
Other (Headache, fatigue, etc)							

**Comments** Please inform me of any other problems you would like to discuss.

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**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Acupuncturist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Informed Consent for Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below named licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, intradermal needles, ear pressballs, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese herbal medicine, and nutritional counseling.

*Heat therapy using moxa (Artemisia), a dried herb, that is lit and burned on the needles or on the skin, or the use of a heat lamp in conjunction with needle therapy. Moxa is not burned directly on the skin, but on top of a burn ointment which will conduct the heat and prevent burns. On rare occasions, a blister may occur. The practitioner will explain the procedure as it is done and the patient is asked to let them know the status of the heat at all times.*

*Application of stainless steel pressballs onto various points in the ear. These are applied with adhesive tape and may be left in the ear for up to 7 days or as suggested by the practitioner.*

*Electrical stimulation of the needles using a battery operated machine to create a current through the needles may be used. This creates a constant vibration through the needles that would be adjusted according to patient comfort.*

*Bloodletting, when appropriate, is used to draw a few drops of blood from points on the body, or more commonly, on the fingertips or toes. A small needle is used to prick the skin and then cotton is applied to draw blood out until it stops.*

*Cupping is a technique used to resolve muscle tightness or help clear the lungs in respiratory conditions. A glass cup is applied to the skin and then a pump suctions the skin and muscle into the cup. The amount of suction is adjusted according to patient comfort. Depending on how tight the muscles are and the amount of restricted blood flow, the cups can leave a reddish or purplish mark on the skin that clears up in a few days, similar to a bruise.*

*Gua sha is a technique similar to cupping where a flat tool is used to scrape the skin to relieve muscle tension and congested blood flow. It leaves a similar bruise-like "rash" that lasts for a few days.*

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 the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. I also understand that any evaluation given to me in no way replaces western (allopathic) medical evaluation, diagnosis and treatment. \_\_\_\_\_

Initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. \_\_\_\_\_

Initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. \_\_\_\_\_

Initials

\_\_\_\_\_  
Patient's Printed Name

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

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Are you Pregnant?

\_\_\_\_\_  
Name of Licensed Acupuncturist

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## PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION

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Your health information in this office will not be shared with anyone who does not require it. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your personal information will not be used for other purposes unless we have asked for and have been given your permission.

Your health information will be used:

1. To provide treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between the practitioner and office staff. We may share your health information, when appropriate, with referring physicians, clinical and pathology laboratories or other health care personnel providing your treatment.
2. To obtain payment: We will use your health information with an invoice to collect payment for treatment you received in this office. We may do this with insurance forms filed for you in the mail.
3. Inspect and copy your health information: You have the right to read, review and copy your health information, including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you to duplicate and assemble your copy.
4. Amend your health information: You have the right to ask us to update or modify your records if you believe they are incorrect or incomplete. We will accommodate you as long as our office maintains this information. Please make your request in writing and inform us of the reason for the change in detail. Your request may be denied if the health information requested was not created by our office, is not part of our records or if the records pertaining to your health information are determined to be accurate and complete.
5. Documentation of your health information: You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment or payment or health care operations. We will be able to provide you a copy of your health information upon request, as long as it is not 7 years or older.
6. Request a paper copy of this notice: Turning Leaf Acupuncture has a more detailed notice on file that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to request a copy of our privacy notices.

I acknowledge that I have read and agree to the above:

Signature of Patient: X \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**Do we have your permission to thank the person who referred you to our practice? Y / N**