NAET and Acupuncture of Boston

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Health History Questionnaire

Help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. If there is anything which you'd like to bring to our attention which is not asked on this form, please note it in the "Comments" section. Thanks.

Name		Date	
Street		Email Address	
City		Home Phone	
State		Cell Phone	
Zip		Occupation	
Physician		Age/DOB	
Emer. Contact		Height/Weight	
Referred By		Marital Status	

Have you been treated by acupuncture or oriental medicine before?	
Main problem(s) you would like help with. Include when each began.	
To what extent does the problem interfere with your daily activities such as work, sleep and sex?	
Have you been given a diagnosis for this problem? If so, what is it?	
What kinds of treatment have you tried?	

1. Your Medical History (include dates)	
Known Allergies (drugs, chemicals, foods)	
Significant Trauma (car accidents, falls, etc.)	
Surgeries	
Significant Illnesses	
Medicines taken within the last 3 months (include drugs, herbs, vitamins)	

Occupational stress (chem., physical, psychological, etc)	
Do you have a regular exercise program? If yes, please describe.	
Describe your average daily diet (morning, afternoon, evening)	
How much water do you drink per day?	
Do you smoke? If yes, how much?	
Amount of coffee, tea, or cola (w/caffeine) drink per week?	

2. General			
"x"	...if you have experienced any of these things in the last 3 months		
	Fevers		Weight loss
	Sweat easily		Strong thirst (hot or cold drinks?)
	Bleed or bruise easily		Fatigue
	Peculiar tastes or smells		Night sweats
	Sudden energy drop (what time of day?)		Cravings
	Poor sleeping		Change in appetite
	Chills		Weight gain

3. Gastrointestinal			
"x"	...if you have experienced any of these things in the last 3 months		
	Nausea		Blood in stools
	Constipation		Rectal pain
	Black stools		Chronic laxative user
	Bad breath		Diarrhea
	Abdominal pain or cramps		Belching
	Any other probs with stomach or intest.		Indigestion
	Vomiting		Hemorroids
	Gas		Poor appetite

4. Respiratory			
"x"	...if you have experienced any of these things in the last 3 months		
	Cough		Pneumonia
	Bronchitis		Production of phlegm, if so what color?
	Difficulty breathing when lying down		Asthma
	Any other lung problems?		Pain with a deep breath
	Coughing blood		

5. Head, eyes, ears, nose and throat			
"x"	...if you have experienced any of these things in the last 3 months		
	Headaches		Vision Changes/Floaters
	Migraines		Other head or neck problems
	Dizziness/Vertigo		Ear aches
	Facial pain		Ringing in ears

	Sinus problems		Poor hearing
	Grinding teeth/TMJ		Recurrent sore throats
	Dental problems		Sores on lips or tongue

6. Skin and Hair			
"x"	...if you have experienced any of these things in the last 3 months		
	Rashes		Eczema
	Itching		Loss of hair
	Dandruff		Hives
	Change in hair or skin texture		Pimples
	Any other hair or skin problems?		Recent moles
	Ulcerations		

7. Musculoskeletal			
"x"	...if you have experienced any of these things in the last 3 months		
	Neck pain		Muscle weakness
	Back pain		Shoulder pain
	Hand/wrist pain		Knee pain
	Any other joint or bone problems?		Foot/ankle pains
	Muscle pain		Hip pain

8. Genito-Urinary			
"x"	...if you have experienced any of these things in the last 3 months		
	Pain upon urination		Unable to hold urine
	Urgency to urinate		Impotence
	Decrease in urine flow		Any particular color to your urine?_____
	Do you wake up to urinate? If Y, how often?		Blood in urine
	Any other prob w/genital or urinary sys?		Kidney stones
	How many times per day do you urinate?		Sores on genitals

9. Cardiovascular			
"x"	...if you have experienced any of these things in the last 3 months		
	High blood pressure		Swelling of hands
	Irregular heart beat		Phlebitis
	Cold hands and feet		Difficulty in breathing
	Blood clots		Chest pain
	Any other heart or blood vessel probs?		Fainting
	Low blood pressure		Swelling of feet

10. Reproductive and Gynecologic			
"x" or #	...if you have ever experienced any of these things		
	Pregnancies (if so, #)		Menopause (if so, age)
	Live births (if so, #)		Irregular periods

	Premature births (if so, #)		Menstrual pain
	Miscarriages (if so, #)		Menstrual clots
	Abortions (if so, #)		Unusual periods (heavy, light, etc)
	Vaginal discharge		Spotting or pain between periods
	Breast lumps		
Age of first menses			
Number of days between periods			
Number of days period lasts			
Date of last period			
Changes in body/psyche prior to period			
Do you practice birth control? If so, what type and for how long?			
Is there a chance you are pregnant now?			
Date of last pap and what were the results?			

11. Neuropsychological			
"x"	...if you have ever experienced/have a tendancy towards any of these things...		
	Anxiety		OCD behavior/Obsessive compulsive
	Depression		Trouble concentrating
	Bad temper/anger		Trouble planning or following through
	Easily susceptible to stress		Sadness
Have you ever been treated for emotional problems?			
Have you ever considered or attempted suicide?			
Any other neurological or psychological problems?			

12. COMMENTS- Please describe any other problems you would like to discuss.			
"x"	...how did you find/learn about us?		
	Google search		Twitter
	Other search engine _____		Facebook
	Referral from _____		Youtube
	NAETAcupunctureBoston.com site		Other _____