

Balanced Health Acupuncture Inc.

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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, please note it in the "Other Concerns" section. Thank you.

Name: _____ Date of first visit: _____

Street Address, City, ST, Zip: _____

Phone: (h) _____ (w) _____ (c) _____

Email: _____ Date of Birth: _____ Age: _____

Occupation: _____ Employer: _____

Primary Care Physician (Name/Phone): _____

Referred by: _____ How did you hear about us: _____

Emergency Contact (Name/Phone): _____ Relation: _____

Insurance Provider: _____

MAIN PROBLEM: Please describe the health concern you wish to address

When did this problem begin? _____

What other treatment(s) have you tried? _____

MEDICAL HISTORY

Please circle all that apply:

<i>Anemia</i>	<i>Arthritis</i>	<i>Asthma</i>	<i>Allergies</i>	<i>Bronchitis/Pneumonia</i>
<i>Cancer</i>	<i>Contagious Illness</i>	<i>Diabetes</i>	<i>Epilepsy/Seizures</i>	<i>Hepatitis</i> <i>Heart Disease</i>
<i>Hemophilia</i>	<i>High Blood Pressure</i>	<i>HIV/AIDS</i>	<i>Mental Illness</i>	<i>Osteoporosis</i>
<i>Thyroid Disease</i>	<i>Venereal Disease</i>	<i>Other:</i>		

Surgeries & Dates: _____

Significant Traumas (falls, accidents, etc.): _____

Location of scars: _____

Allergies (food, chemical, drugs, environmental): _____

Name: _____ Date: _____

LIFESTYLE

Please describe your average daily diet:

Morning	Afternoon	Evening

Cravings (please circle): Salt Sweet Sour Other _____

How many cups/week do you drink: Alcohol _____ Coffee _____ Soda _____ Water _____

Cigarette use (please circle): Past use Current use

Have you ever taken illicit drugs or prescription medication for non-medical use? If so, what and when: _____

Do you have a regular exercise routine? Y N If yes, please describe: _____

Describe your spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Rate your average energy level on a scale of 1-10 (1=can barely get out of bed; 10=unlimited energy): _____

My energy level is (check all that apply): Low in the morning Low in the evening Same throughout day

Do you enjoy work? Y N Why/Why not? _____

Rate your average stress level on a scale of 1-10 (1=very little stress; 10=constant stress): _____

How do you relieve your stress: _____

How many times in a week do you feel the following:

Irritable _____ Anxious _____ Guilt _____ Depression _____ Overjoyed _____

Angry _____ Worry _____ Fear _____ Sadness _____ Grief _____

Are you currently taking any medication for anxiety or depression? Please list: _____

Please list all prescription medications you are currently taking, over the counter drugs, supplements & herbs:

Medication	Reason for Use

Name: _____ Date: _____

Please check any of the following you have had in the last three months:

General Health

- | | | |
|--|---|---|
| <input type="checkbox"/> Temperature always warm | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Strong thirst (hot or cold drinks) |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Bleed or bruise easily |

Skin & Hair

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Scars | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Premature graying of hair | <input type="checkbox"/> Any other hair or skin problems? |

Head, eyes, ears, nose, and throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Nasal congestion |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Any other head or neck problems? |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Any other heart/blood problems? |
| <input type="checkbox"/> Low blood pressure | | |

Respiratory

- | | | |
|---|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Wheezing while breathing | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Pain with a deep breath |
| <input type="checkbox"/> Production of phlegm | <input type="checkbox"/> Any other lung problems? | |

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Stomach noises |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Any other problems with your stomach or intestines? | | |

Urinary

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Any particular color to your urine: |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Decrease in flow | |
| <input type="checkbox"/> Do you wake up to urinate? How often? | | |
| <input type="checkbox"/> Any other problems with your or urinary system? | | |

Name: _____ Date: _____

Neurological

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Tremors (where?) |
| <input type="checkbox"/> Any other neurological problems? | | |

Men's Health

- | | | |
|---|--|---|
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Testicular pain/injury |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Spermatorrhea | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Benign Prostatic Hypertrophy | <input type="checkbox"/> Low motility | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Any other reproductive problems? | | |

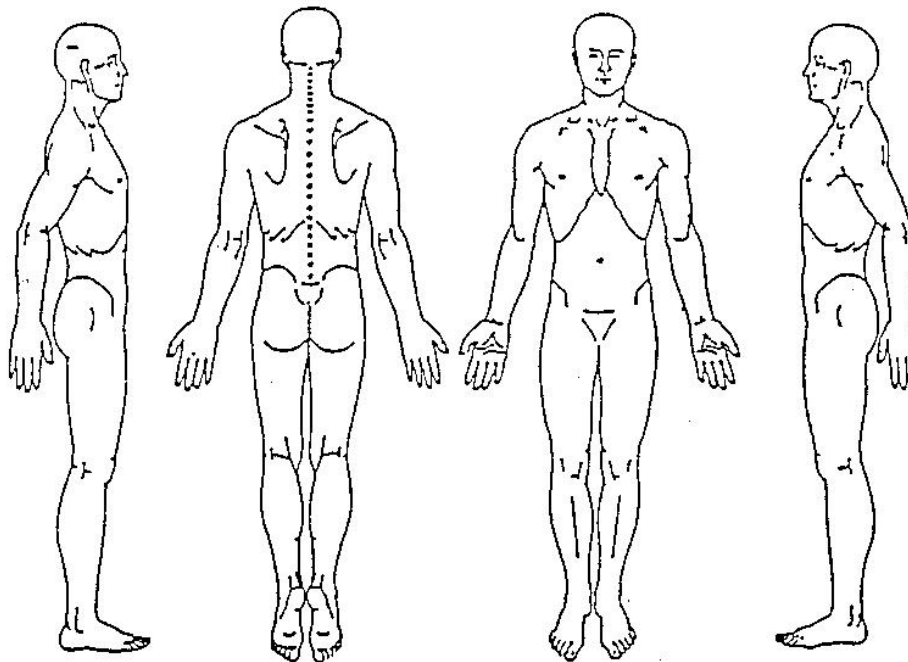
Women's Health

Are you pregnant? Yes No

Is it possible that you are pregnant? Yes No

- | | | |
|---|--|--|
| <input type="checkbox"/> Age of first menses: _____ | <input type="checkbox"/> Pregnancies #: _____ | <input type="checkbox"/> Menopause Age: _____ |
| <input type="checkbox"/> Duration of menses: _____ | <input type="checkbox"/> Live births #: _____ | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Time between menses: _____ | <input type="checkbox"/> Premature births #: _____ | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Miscarriages #: _____ | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Abortions #: _____ | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Unusual character | <input type="checkbox"/> Infertility | <input type="checkbox"/> Western Fertility Treatment |
| <input type="checkbox"/> PMS symptoms. Describe: | | |
| <input type="checkbox"/> Do you practice birth control? What type and for how long? | | |
| <input type="checkbox"/> Any other reproductive problems? | | |

Pain Assessment. Please circle the areas where you are currently experiencing pain:



Other Concerns: _____

Patient Signature: _____ Date: _____