Health History Questionnaire

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In order for us to better service you please fill out this questionnaire carefully. All of your answers will be held absolutely confidential. It there is anything you want to bring to our attention, which is not asked on this form, please note in the "comments" section. Thank you.

Name: Sex: Male Female

Date of birth: Referred by: Occupation:

Address:

Cell phone: **email:**

Marital status Emergency contact

Have you been treated with acupuncture or oriental medicine before? Yes No
Main concern(s) you would like for us to help you with

When did this problem begin? Please be specific

To what extent does this problem interfere with your daily activities?

Have you been given a diagnosis for this problem? If so, what?

What kind of treatment have you tried?

Medical History (please specify all that apply)

Cancer	Diabetes	Hepatitis A B C	High blood pressure
Heart disease	Rheumatic fever	Seizures	Stroke
Thyroid disease	Venereal Disease	Other	

Surgeries
Significant trauma (auto accidents, falls, etc.)

Allergies (drugs, chemicals, foods)

Medications taken in the past two months (vitamins, drugs, herbs, etc.)

Have you ever been on a restricted diet? If yes, what kind?

Do you smoke? If yes, how much?

Please describe any use of drugs for non-medical purposes.

Indicate any painful or distressed areas:

Please specify if you have had (in the past three months):

General

Poor sleeping	Night sweats	Fevers	Chills
Cravings	Sweat easily	Weight loss	Change in appetite
Bleed or bruise easily	Strong thirst (hot or cold drinks)		Weight gain
Peculiar tastes or smells	Fatigue		
Sudden energy drop (what time of a day?)			

Skin & Hair

Rashes	Ulceration	Hives	Fevers
Itching	Eczema	Pimples	Dandruff
Loss of hair	Recent moles	Changes in hair or skin texture	
Any other hair or skin problems			

Head, eyes, ears, nose, and throat:

Dizziness	Concussions	Migraines	Glasses
Eye strain	Eye pain	Poor vision	Night blindness
Color blindness	Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes	
Sinus problems	Nose bleeds	Recurrent sore throats	

Grinding teeth	Facial pain	Sores on lips or tongue
Teeth problems	Jaw clicks	Headaches (where, when?)

Cardiovascular:

High blood pressure	Low blood pressure	Chest pain
Irregular heartbeat	Swelling of hands	Fainting
Cold hands and feet	Phlebitis	Swelling of feet
Blood clots	Difficulty in breathing	

Any other heart and blood vessel problems

Respiratory:

Cough	Coughing blood	Asthma
Bronchitis	Pneumonia	Pain with a deep breath
Difficulty in breathing when take deep breath		Production of phlegm; what color
Broncheectosis	Loss of sense of smell and taste	Sneezing and sinisitis

Gastrointestine

Nausea	Vomiting	Diarrhea
Constipation	Gas	Belching
Black stool	Blood in stools	Indigestion
Bad breath	Rectal pain	Hemorrhoids
Abdominal pain or cramps	Chronic laxative use	Poor appetites

Any other problems with your stomach or intestines

Genito-Urinary

Pain upon urination	How many times per day do you urinate:		
Blood in urine	Urgency to urinate	Unable to hold urine	
Kidney stones	Decrease in urine flow	Impotence	Impotence
Sores on genitals	Do you wake up to urinate? How often		

Any particular color of your urine

Any other problems with your genital or urinary system

Musculoskeletal

Neck pain	Muscle pain:	Knee pain	Back pain
Muscle weakness	Foot/ankle pains	Hand/wrist pains	Shoulder pain
Hip pain	Any other joint or bone problems		

Neuropsychological

Seizure	Lack of coordination	Loss of balance
Areas of numbness	Depression	Poor memory
Concussion	Easily susceptible to stress	Anxiety
Bad temper	Tremors	

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Please answer the following questions about Covid-19:

Please answer the following questions about Covid-19:

1. Have you traveled outside of Massachusetts within the last 14 days in the Airplane?

Yes No

If yes, where did you travel to?

If yes, is your Covid-19 test negative?

2. Have you or anyone in your home been hospitalized within the last 14 days?

Yes No

If yes, what for?

3. Have you or anyone in your home visited an urgent care facility within the last 14 days?

Yes No

If yes, what for?

4. Have you been in contact with anyone who has tested positive for Covid-19 or anyone that has any symptoms of the Covid-19/coronavirus within the last 14 days?

Yes No

5. Do you have coughing, difficulty breathing, loss of taste and smell sensation, headache, fatigue, body aches and high fever?

Yes No

If you do have the symptoms, please contact your physician for testing and treatment before coming in for acupuncture treatment.

All patients are required to wear a mask that covers your nose and mouth when you come into the office and during acupuncture treatments.

Thank you for protecting yourself and other patients

I testify that I will be treated by Li Zheng and Changhong Zhou, PhD, Licensed Acupuncturist and Herbalist, Boston Chinese Acupuncture Clinic for my medical condition under my own choice.

I understand the risks of the Covid-19 virus and I am using precautionary measures to avoid contracting it. I agree that Boston Chinese Acupuncture Clinic is in compliance with the precautionary measures needed to protect me during my acupuncture treatment.

Signature

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