Acupuncture & Oriental Medicine of Sturbridge
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HEALTH HISTORY

Name		Today's Date	
DOB	Age	Height	Weight
Referred By		Have you tried Oriental Medicine Before?	
Address			
City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	
Email		Occupation	
Primary Care Physician		Insurance plan	

MAIN COMPLAINT

- Please list the main issue that brings you in for Acupuncture & Oriental Medicine:
- When did this problem begin?
- Did anything occur that could have brought this on that you are aware of?
- Have you been given a diagnosis for this?
- Have you tried other treatments for this condition? If so, what & are you still?
- Please list any secondar y issues you would like to have addressed:

ACTIVITIES

Please refer to the section below & indicate with an"X" in the correct box the degree in which your condition interferes with the following activities -

ACTIVITY	NEVER DIFFICULT	SOMETIMES DIFFICULT	FREQUENTLY DIFFICULT	ALWAYS DIFFICULT
SLEEP	❍	❍	❍	❍
EATING	❍	❍	❍	❍
SPORTS	❍	❍	❍	❍
SCHOOLWORK	❍	❍	❍	❍
JOB	❍	❍	❍	❍
SOCIAL ACTIVITIES	❍	❍	❍	❍
HOUSE CHORES	❍	❍	❍	❍
DRIVING	❍	❍	❍	❍
WALKING	❍	❍	❍	❍
SEX	❍	❍	❍	❍
OTHER (PLEASE SPECIFY)	❍	❍	❍	❍

PAST MEDICAL HISTORY

- Surgeries & Dates:

- Siginificant Trauma & Dates (auto accidents, falls, etc.):

- Allergies (drugs, chemicals, foods,etc):

Please "X" any of the following that you currently exerpience -

Siginifcant Illnesses:

❒ Cancer	❒ Veneral Disease	❒ Impotence	❒ Heart Disease
❒ Diabetes	❒ Lyme Disease	❒ Raynaud's Disease	❒ Chronic Pain
❒ Seizures	❒ Asthma	❒ Emphysema	❒ Fibromyalgia
❒ Hepatitis	❒ Anemia	❒ Ulcer	❒ Food Allergies
❒ High Blood Pressure	❒ Stroke	❒ Chronic Fatigue	❒ Other:
❒ High Cholesterol	❒ Arthritis	❒ Polycystic Ovaries	❒
❒ Thyroid Imbalance	❒ Infertility	❒ Irritable Bowel	❒

Family History:

❒ Cancer	❒ Veneral Disease	❒ Impotence	❒ Heart Disease
❒ Diabetes	❒ Lyme Disease	❒ Raynaud's Disease	❒ Chronic Pain
❒ Seizures	❒ Asthma	❒ Emphysema	❒ Fibromyalgia
❒ Hepatitis	❒ Anemia	❒ Ulcer	❒ Food Allergies
❒ High Blood Pressure	❒ Stroke	❒ Chronic Fatigue	❒ Other:
❒ High Cholesterol	❒ Arthritis	❒ Polycystic Ovaries	❒
❒ Thyroid Imbalance	❒ Infertility	❒ Irritable Bowel	❒

LIFESTYLE

- Smoke (# per day) _____ Caffeinated drinks (per day) _____ Alcohol (per week) _____
- Meals (per day) _____ Fruit & vegetable servings (per day) _____ Daily water intake _____

- Do you follow a particular diet regimen? _____If so what?

- Please list your average daily meals:
  - Breakfast _____
  - Lunch _____
  - Dinner _____

- Do you have a regular exercise routine?
  - Days per week _____ Length of workout _____
  - Type(s) of activity(s) _____

- Please list any drug(s) you take for non-medical purposes

- Describe any occupational stress (chemical, physical, psychological, etc.)

PAST 3 MONTHS

Please check off all of the following that you have experienced in the past 3 months -

GENERAL

❒ Pooer appetite	❒ Poor sleeping	❒ Fatigue
❒ Fevers	❒ Chills	❒ Night sweats
❒ Sweat easily	❒ Tremors	❒ Cravings
❒ Localized weakness	❒ Poor balance	❒ Change in appetite
❒ Bleed or bruise easily	❒ Weight loss	❒ Weight gain
❒ Peculiar tates or smells	❒ Strong thirst (cold or hot drinks)	❒ Sudden energy drop -time of day?

SKIN & HAIR

❒ Rashes	❒ Ulcerations	❒ Hives
❒ Itching	❒ Eczema	❒ Pimples
❒ Dandruff	❒ Loss of hair	❒ Recent moles
❒ Change in hair or skin	❒ Any other hair / skin problems?	

HEAD, EYES, EARS, NOSE & THROAT

❒ Dizziness	❒ Concussion	❒ Migraines
❒ Glasses	❒ Eye strain	❒ Eye pain
❒ Poor Vision	❒ Night blindness	❒ Color blindness
❒ Cateracts	❒ Blurry vision	❒ Earaches
❒ Rining 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?
❒ Any other head or neck problems?		

CARDIOVASCULAR

❒ High Blood Pressure	❒ Low blood pressure	❒ Chest pain
❒ Irregular heartbeat	❒ Dizziness	❒ Fainting
❒ Cold hands or feet	❒ Swelling of hands	❒ Swelling of feet
❒ Blood clots	❒ Phlebitis	❒ Difficulty breathing
❒ Any other heart or blood vessel problem?		

RESPIRATORY

❒ Cough	❒ Coughing blood	❒ Asthma
❒ Bronchitis	❒ Pneumonia	❒ Pain with deep breath
❒ Difficulty breathing when lying down		❒ Any other lung problems?
❒ Production of phlegm - color?		

GASTROINTESTINAL

❒ Nausea	❒ Vomiting	❒ Diarrhea
❒ Constipation	❒ Gas	❒ Belching
❒ Black stools	❒ Blood in stools	❒ Indigestion
❒ Bad breath	❒ Rectal pain	❒ Hemmerhoids
❒ Abdominal pain or cramps	❒ Chronic laxitive use	
❒ Any other problems with your stomach or intestines?		

GEITO-URINARY

❒ Pain on urination	❒ Frequent urination	❒ Blood in urine
❒ Urgency to urinate	❒ Unable to hold urine	❒ Kidney stones
❒ Decrease in flow	❒ Impotency	❒ Sores on genitals
❒ Wake up to urinate – how often?		❒ Particular color to urine?
❒ Any other problems with your gential or urinary system?		

PREGNANCY & GYNECOLOGY

❒ _____# of Pregnancies	❒ _____# of Births	❒ _____# of Premature births
❒ _____# of Miscarriages	❒ _____# Abortions	❒ _____Age at first menses
❒ _____Time between meses	❒ _____Duration of flow	❒ _____First date of last meses
❒ Unusal character – heavy or light		❒ Painful Periods
❒ Clots	❒ Irregular periods	❒ Vaginal discharge
❒ Vaginal sores	❒ Breast lumps	❒ _____Last PAP
❒ Changes in body/psyche prior to menstration		
❒ Do you practice birth control? _____ What type & for how long? _____		

MUSCULOSKELETAL

❒ Neck pain	❒ Muscle pain	❒ Knee pain
❒ Back pain	❒ Muscle weakness	❒ Foot / ankle pain
❒ Hand / wrist pain	❒ Shoulder pain	❒ Hip pain
❒ Any other joint or bone problem?		

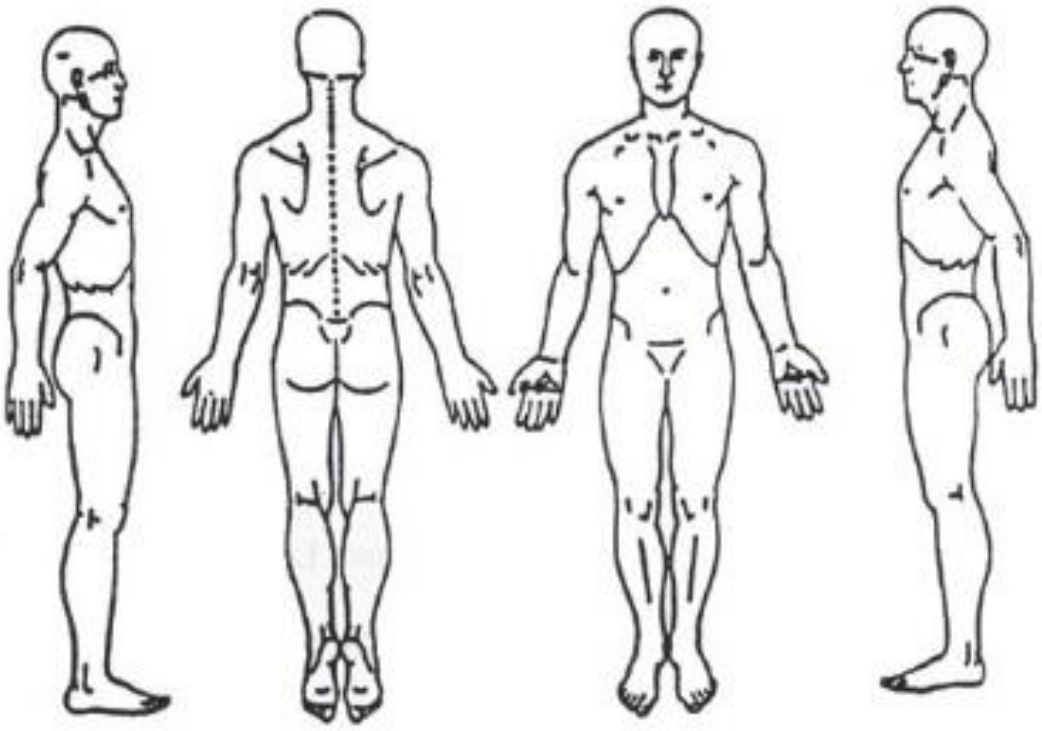
NEUROPSYCHOLOGICAL

❒ Seizures	❒ Dizziness	❒ Loss of balance
❒ Areas of numbness	❒ Lack of coordination	❒ Poor memeory
❒ Concussions	❒ Depression	❒ Anxiety
❒ Bad temper	❒ Easily succeptible to stress	
❒ Have you ever been treated for emotional problems?		
❒ Have you ever considered or attempted suicide?		
❒ Any other neurological or psychological problems?		

***ADDITIONAL COMMENTS –** Is there any other problem you would like to discuss?

PAIN ASSESSMENT

Please indicate where you experience pain on the diageram below.
Shade in the areas with the most severe pain darker.



Pain Scale

Rate the severity of your pain by checking 1 box on the following scale:

1 → Least Pain

10 → Extreme Pain

EXTREME

10

9

8

7

6

5

4

3

2

1

0

NO PAIN

- How did your pain begin?

- When do you have pain? ____All of the time _____On & Off

- Is you pain worse with any of the follwing:

  ❒ **Sitting** ❒ **Bending** ❒ **Walking** ❒ **Lifting** ❒ **Rest**

- Do you feel like your condition is _____Temporary? _____Permanent? _____ Don't know?

- Please list any additional comments: