***BOSTON ACUPUNCTURE OASIS***

**Health History Questionnaire**

**DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Emergency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What conditions or symptoms would you like to address with acupuncture?**

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark the picture where you have pain or other symptoms:**

 If there is pain, please indicate the intensity:

 **No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain**

Is there anything that provides relief of symptoms?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes them worse?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of treatment have you had for this problem in the past?

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**Medical History**

Do you have, or have you ever had, any of the following conditions? If yes, please indicate the date of your diagnosis.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Diagnosis Date  |  | Diagnosis Date |
| Cancer: Type \_\_\_\_\_ |  | HIV |  |
| Diabetes |  | Mental Illness: |  |
| Hepatitis: Type \_\_\_ |  |  Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| High Blood Pressure |  | Seizures |  |
| Heart Disease |  | Stroke |  |
| Heart Attack |  | Thyroid Disorder |  |

Please list any hospitalizations or surgeries with dates

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

Please list all medications you have taken in the past 3 months:

|  |  |  |
| --- | --- | --- |
| Medication | For Treatment of: | Side Effects: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you have a pacemaker or any metal devices in your body? Y / N

**Family History**

Please list any major diseases or illnesses in your family and the family member affected.

|  |  |  |  |
| --- | --- | --- | --- |
| Illness | Family Member | Illness | Family Member |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please describe any exercise routine you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per night do you sleep? \_\_\_\_\_\_ Do you wake rested? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Y/N If yes, how many cigarettes per day? \_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Y/N If yes, how many drinks per week? \_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

**Energy and Immunity:**

\_\_ Fatigue

\_\_ Allergies (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Anemia

\_\_ Chronic Fatigue Syndrome

\_\_ Thyroid problems (Specify)\_\_\_\_\_\_\_\_\_\_\_

\_\_ Frequent colds

**Head, Eye, Ear, Nose, and Throat:**

\_\_ Headaches / Migraines

\_\_ Dry eyes

\_\_ Blurry vision

\_\_ Poor night vision

\_\_ Vertigo / Dizziness

\_\_ Difficulty concentrating /

 poor memory

\_\_ Ringing in ears

\_\_ Hearing loss

\_\_ Teeth grinding

\_\_ TMJ

\_\_ Sinus congestion

\_\_ Mouth sores / bleeding gums

**Respiratory / Circulatory**

\_\_ Shortness of breath

\_\_ Asthma / wheezing

\_\_ Cough

\_\_ Chest pain

\_\_ Palpitations / Fluttering

\_\_ Chest pain

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal**

\_\_ Heartburn / Acid Reflux

\_\_ Ulcers

\_\_ Nausea / Vomiting

\_\_ Bloating / Gas

\_\_ Cramps

\_\_ Constipation

\_\_ Diarrhea or loose stool

\_\_ Hemorrhoids

\_\_ Blood in stool

\_\_ Poor appetite

\_\_ Excessive appetite / hunger

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kidney / Urinary**

\_\_ Painful urination

\_\_ Frequent urinary tract infections

\_\_ Frequent / urgent urination

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Temperature**

\_\_ Feel cold easily

\_\_ Feel warm/hot easily

\_\_ Hot flashes

\_\_ Night sweats

\_\_ Excessive thirst

**Sleep / Emotions**

\_\_ Insomnia

\_\_ Nightmares

\_\_ Worry

\_\_ Anxiety

\_\_ Panic Attacks

\_\_ Depression

\_\_ Irritability / Anger

\_\_ Fear

\_\_ Grief

\_\_ Mood swings

\_\_ Difficulty making decisions

**Musculo-skeletal**

\_\_ Arthritis: area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Tendontiis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Bursitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Fibromyalgia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Other painful areas, with or without diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women’s Health**

\_\_ Menopausal symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Irregular periods

\_\_ Painful periods

\_\_ Spotting before or between periods

\_\_ PMS (symptoms:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Heavy periods

\_\_ Menstrual clots

\_\_ Endometriosis

\_\_ Fibroids

\_\_ Ovarian cysts

\_\_ PCOS

\_\_ Frequent yeast infections

\_\_ Pain with intercourse

\_\_ History of miscarriage

\_\_ Other fertility problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Men’s Health**

\_\_ Enlarged prostate

\_\_ Fertility problems

\_\_ Erectile dysfunction

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT / POLICIES**

I agree to receive therapies from a licensed acupuncturist at Boston Acupuncture Oasis. Occasionally additional techniques can be used along with acupuncture, which may include electro-acupuncture, moxabustion, cupping, gwa sha, pressballs, or magnets.

 **Acupuncture**: Insertion of fine solid needles into the body. There may be some sensation such as heaviness, numbness, warmth, tingling, or an electrical sensation, which should not be associated with pain, and is normal. There may be some residual sensation following the removal of the needles. Although care is taken on insertion, occasionally bruising or sensitivity at the insertion point may occur and resolves within a few days.

 **Electro-acupuncture**: A small battery-powered stimulator can be applied to the needles. A slight vibratory sensation is felt with the use of this technique.

 **Moxabustion**: The burning of the herb Artemesa Vulgaris may be done above, or directly on the skin. With any type of heat application, including moxabustion or a heat lamp, there is the risk of a burn, blister or small scar, though care is taken to avoid it. When direct moxa is used, a protective layer of ointment is applied between the skin and the moxa.

 **Cupping:** Cupping is a form of bodywork that employs small, round, glass suction cups to raise tissue and release rigidity in muscles. Cups are likely leave bruise marks that last for the typical duration of a bruise. Moving or sliding cups may be used, that are less likely to leave marks.

 **Gwa Sha**: Gwa Sha is a form of bodywork that employs a scraping technique to release rigidity from muscle tissue. Gwa Sha is likely to leave bruise marks that last for the typical duration of a bruise.

 **Press Balls**: Following treatment, tiny stainless steel press balls may be taped to specific points to provide a slight, ongoing stimulation . If there is any irritation, discomfort or problem simply remove and discard. Press balls are typically kept on the skin from 3 to 4 days. Remove after that length of time or sooner.

 **Magnets:** Magnets may be used during treatment, or taped to specific points following treatment. Magnets can stay on the skin from 12 hours to 3 days. Remove after that time or sooner.

**Certain types of treatment are contraindicated for pregnant women. If I become pregnant or suspect I am pregnant, I will notify the practitioner before treatment.**

I agree to provide payment at the time of treatment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_