Good Life Acupuncture & Holistic Therapies
102 W. Center Street – The Carriage House #5 - West Bridgewater, MA 02379

Health History

Client Name: _____ **Date:** _____

Have you had acupuncture before? YES / NO

If so, when and for what: _____

Have you ever been on antibiotics? YES / NO

If so, when & for what? _____

Describe your job/profession: _____

How many hours/week do you work? _____ Are you happy with your work? YES / NO

DIET DESCRIPTION: _____

_____

_____

_____

_____

- How many meals/day do you eat? _____
- Are you a vegetarian or vegan? YES / NO
- Do you have any food allergies? YES / NO If yes, what kind? _____
- How much water do you drink each day? _____
- Do you drink caffeinated beverages? YES / NO If yes, describe: _____
- Do you drink coffee? YES / NO How many cups? _____
- Do you drink tea? YES / NO What type? _____ How many cups? _____
- Do you drink diet soda? YES / NO If yes, how much? _____/ _____
- Do you drink regular soda? YES / NO If yes, how much? _____/ _____
- Do you drink alcohol? YES / NO If yes, _____ per _____
- Are you in recovery? YES / NO If yes, describe: _____
- For how long? _____
- Do you have an eating disorder? YES / NO If yes, please describe: _____
- When? _____
- Do you currently smoke? YES / NO How much per day? _____
- Have you ever smoked? YES / NO If yes, when & for how long? _____
- Do you currently use street drugs? YES / NO If yes, what? _____
- Have you ever attempted or seriously considered suicide? YES / NO
- If yes, when? _____
- Are you currently in therapy? YES / NO

Health History

Client Name: _____ **Date:** _____

Please list any chronic health conditions: _____

_____

_____

_____

Please list types and dates of Surgeries/Hospitalizations: _____

_____

_____

_____

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

_____

_____

Have you ever been in an auto accident? YES / NO If YES, when? _____

_____

Do you have, or have you ever been diagnosed with, an autoimmune disease? YES / NO

If yes, what: _____

_____

List any non-food allergies (foods, drugs, chemicals): _____

_____

Do you exercise regularly? YES / NO _____

If yes, please describe: _____

_____

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PLEASE CHECK ALL THAT APPLY.

FAMILY MEDICAL HISTORY				
○ High Blood Pressure	○ High cholesterol	○ Auto-immune	○ Thyroid Disease	○ Psychological Issues
○ Asthma	○ Heart Disease	○ Stroke	○ Seizures	○ Cancer
	○ Allergies	○ Arthritis	○ Diabetes	○ Other: _____

YOUR PERSONAL MEDICAL HISTORY				
○ High Blood Pressure	○ Diabetes	○ Eating Disorder	○ IBS	○ Colitis
○ Asthma	○ Heart Disease	○ Stroke	○ Seizures	○ Cancer
○ Ulcer	○ Allergies	○ STD	○ Thyroid Disorder	○ Hepatitis
	○ Rheumatic Fever	○ Diabetes	○ Arthritis	○ Other: _____

GENERAL		
○ Fever or chills	○ Night Sweats / Sweating easily	○ Bleed/bruise easily
○ Particular taste/smell	○ Lack of or little sweating	○ Poor sleeping
○ Fatigue	○ Weight Loss	○ Strong thirst (craves hot / cold)
○ Pain	○ Weight Gain	○ Change in appetite
○ Autoimmune Disease	○ Cravings (for _____)	○ Grief / Sadness / Loss
○ Irritability or anger	○ Chronic headache	○ Mood Swings
○ Specific taste/smell	○ Infectious Disease	○ Thirst without desire to drink
○ Hot Flashes	○ Worry	○ Other
	○ Other	○ Other

SKIN / HAIR:		
○ Itching	○ Dandruff	○ Rash / Dermatitis
○ Ulcerations / boils	○ Hives	○ Acne / blemishes
○ New moles	○ Hair loss / thinning	○ Eczema
○ Psoriasis	○ Change in skin /hair texture	○ Brittle nails
○ Nail fungus	○ Oily skin	○ Other
	○ Other	○ Other

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RESPIRATORY		
○ Cough	○ Pain	○ Shortness of breath
○ Bronchitis	○ Blood in sputum	○ Asthma
○ Difficulty breathing	○ Pneumonia	○ Pain /tightness with deep inhalation
○ COPD	○ Phlegm	○ Frequent colds
	○ Other	○ Other

HEAD, EYES, EARS, NOSE, & THROAT		
○ Dizziness / lightheadedness	○ Concussion	○ Migraine or Clusters
○ Headache	○ Glasses	○ Eye strain / twitching / pain
○ Poor vision	○ Night / color blindness	○ Cataracts
○ Blurry vision	○ Earaches	○ Ear ringing
○ Poor hearing	○ Spots in front of eyes	○ Sinus problems:
○ Nosebleeds	○ Recurring sore throat	○ Teeth grinding
○ Facial pain	○ Sores: lips, mouth or tongue	○ Teeth/gum problems
○ TMJ / jaw issues	○ Neck pain / stiffness	○ Swallowing problems
○ Glaucoma	○ Detached Retina	○ Red/Itchy eyes
○ Cataracts	○ Excess dryness / tearing	○ Other
		○ Other

CARDIOVASCULAR		
○ High blood pressure	○ Blocked Arteries	○ Chest pain
○ Irregular heartbeat	○ Low blood pressure	○ Fainting
○ Cold hands / feet	○ Swelling of hands / feet / legs	○ Blood clots
○ Difficulty breathing	○ Phlebitis	○ Varicose Veins
○ High Cholesterol	○ Pacemaker	○ Heart Disease
○ Palpitations	○ Tachycardia	○ Valve Issues
	○ Heart murmur	○ Other

GASTROINTESTINAL		
○ Nausea	○ Heartburn	○ Diarrhea
○ Constipation	○ Vomiting	○ Belching
○ Black stools	○ Gas	○ Indigestion
○ Bad breath	○ Blood in stools	○ Hemorrhoids
○ Abdominal pain / cramping	○ Rectal pain	○ Poor appetite
○ Acid Reflux / GERD	○ Chronic laxative use	○ Ulcer
○ Diverticulitis	○ Esophagus issues	○ Crohn's Disease
	○ Colitis	○ Other

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GENITO-URINARY		
○ Pain with urination	○ # times / day _____	○ Blood in urine
○ Urgency	○ Incontinence	○ Kidney stones
○ Decrease in amount	○ Impotence	○ Genital sores
○ Wake up to urinate	○ Cloudy urine	○ Burning Sensation
	○ Mucous in urine	○ Other

MUSCULO-SKELETAL/NEURO		
○ Neck pain	○ Knee: pain / weakness	○ Back pain / weakness
○ Muscle pain / weakness	○ Hand / wrist: pain / weakness	○ Foot / ankle pain / weakness
○ Shoulder pain / stiffness / weakness	○ Hip pain	○ Tingling / numbness
○ Lack of coordination	○ Loss of balance	○ Osteoporosis
○ Herniated disc	○ Hernia	○ Carpal Tunnel
○ Sciatica	○ Muscle spasms	○ Tendonitis
○ Bursitis	○ Sprains	○ Fractures/bone breaks
	○ Other	○ Other

NEUROPSYCHOLOGICAL		
○ Seizures	○ Depression	○ Poor memory
○ Concussion	○ Stress	○ Bad temper
○ Tremors	○ Bipolar Disorder	○ Schizophrenia
○ Seasonal Mood Disorder	○ Anxiety	○ Mind racing
○ Obsessive-compulsive	○ ADD / ADHD	○ Autism
	○ Other	○ Aspergers

ENDOCRINE		
○ Thyroid disease	○ Diabetes, Type: _____	○ Kidney Disease
○ Adrenal Issues	○ Other: _____	○ Pituitary Issues

SLEEP		
Hrs/Night: _____	○ Trouble staying asleep	○ Wake up to urinate
○ Restlessness	○ Wakes up during night	○ Nightmares/disturbing dreams
○ Restless Leg Syndrome	How many times/night?	○ Wake up tired
	Do you wake up at the same times?	○ Sleep is disturbed by spouse, children, pets, etc.
○ Trouble falling asleep	○ Other	○ Other

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OTHER		
○ Lyme Disease	○ Fibromyalgia	○ Hepatitis
○ STD	○ Chronic Fatigue Syndrome	○ Anemia
○ HIV	○ Toxic Mold Syndrome	○ Cancer
○ Chemical Exposure	○ Chemotherapy	○ Radiation
○ Blood related disease	○ Gallbladder Disease	○ Liver Issues
	○ Chromosomal abnormality	○ Other

WOMEN:		
○ Vaginal discharge	○ Menstrual pain / clots	○ Breast lumps / discharge
○ Flow (amt.): _____	○ Blood color: _____	○ Spotting
○ Pain mid-cycle	○ PMS	○ Irregular periods
○ # pregnancies: _____	○ # births: _____	○ # premature births: _____
○ # abortions: _____	○ # miscarriages: _____	○ Age of 1st period: _____
○ Menopause age: _____	○ Date of last PAP smear: _____	○ Date last breast exam _____
○ Date of last period: _____	○ #Days between periods _____	○ # days period lasts _____
○ Birth control type:	○ Are you pregnant now?	○ Low or Excessive Libido
○ Nipple Discharge	○ Breast Issues	○ Lumpectomy
	○ Other	○ Mastectomy

Ages of children: _____ Are you currently sexually active? YES / NO
Have you had IUI / IVF? YES / NO Were your deliveries vaginal or caesarian? _____
Notes: _____
_____
_____

MEN:		
○ Penile discharge	○ Difficult urination	○ Erectile dysfunction
○ Prostate Issues	○ Nipple discharge	○ Low sperm count
○ No. of children: _____	○ Low testosterone	○ Low sperm motility
○ STD history	○ Date of last physical exam: _____	○ Testicular issues.
○ Vasectomy	○ Premature ejaculation	○ Low or Excessive Libido
	○ Infertility	○ Other

Ages of Children: _____ Are you currently sexually active? YES / NO
Notes: _____
_____
_____
_____