Ancient Path
Acupuncture and Herbs

394 Lowell Street, Suite 16
Lexington, MA 02420
Tel: 781-863-0066
Fax: 781-357-1911

Acupuncture & Herbal Clinic
of Westborough

33 Lyman Street, Suite 203B
Westborough, MA 01581
Tel: 508-366-5773

www.ancientpathweb.com

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 any questions, please ask the practitioner. If there is anything you wish to bring to our attention, which is not asked on this form, please note it in the "COMMENTS" section. Thank you.

Name			Date of Birth	Home Phone
Address/City				Work Phone
State	Zip	Email		Cell Phone
Occupation		Marital Status	Height	Weight
Emergency Contact: Name				Relationship:
Phone			Email	
Family Physician			Referred by	
Insurance Company			Policy Number	

Main Problem(s) you would like us to help you with:

How long ago did this problem begin? (please be specific)

To **what extend** does this problem interfere with your daily activities (such as work, sleep, sex, etc.)?

Have you been given a **diagnosis** for this problem? If yes, what is it?

What kinds of **treatment** have you tried?

Have you ever been treated by oriental medicine (including acupuncture, herbs, etc.)? ☐ Yes ☐ No

PAST MEDICAL HISTORY (please include date)

Significant Illness

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Rheumatic Fever

☐ Hepatitis ☐ Seizures ☐ Thyroid Disease ☐ Venereal Disease ☐ Other

Surgeries

Significant trauma (auto accidents, falls, etc.)

Allergies (drugs, chemicals, foods, etc.)

FAMILY MEDICAL HISTORY

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke

☐ Asthmas ☐ Seizures ☐ Allergies ☐ Other

Ancient Path
Acupuncture and Herbs

394 Lowell Street, Suite 16
Lexington, MA 02420
Tel: 781-863-0066
Fax: 781-357-1911

Acupuncture & Herbal Clinic
of Westborough

33 Lyman Street, Suite 203B
Westborough, MA 01581
Tel: 508-366-5773

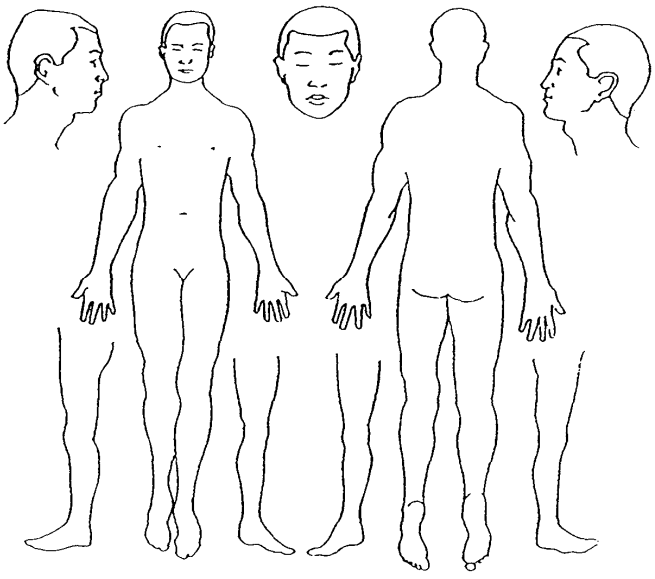
www.ancientpathweb.com

Medicines taken within the last two months (drugs, vitamins, herbs, etc.)
Occupational stress (chemical, physical, psychological, etc.)
Do you have a regular exercise program? If yes, please describe it.
Have you ever been a restricted diet? If yes, what kind?

Please describe your average daily diet		
Morning	Afternoon	Evening

How much water do you drink per day?
Do you smoke? If yes, how much per day (week)?
How much caffeinated coffee, tea, or cola do you drink per day?
How much alcoholic drink/beverages do you drink per day?
Please describe any use of drugs for non-medical purpose:

PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS



PLEASE CHECK IF YOU HAVE HAD (IN THE LAST THREE MONTHS):

GENERAL

☐ Poor Sleeping	☐ Night sweats	☐ Fever	☐ Chills
☐ Sweat Easily	☐ Cravings	☐ Change in Appetite	☐ Weight Loss
☐ Weight Gain	☐ Bleed or Bruise Easily	☐ Fatigue	☐ Peculiar Taste or Smell
☐ Strong Thirst (hot or cold drinks)	☐ Sudden Energy Drop (what time of day?)		

Ancient Path
Acupuncture and Herbs

394 Lowell Street, Suite 16
Lexington, MA 02420
Tel: 781-863-0066
Fax: 781-357-1911

Acupuncture & Herbal Clinic
of Westborough

33 Lyman Street, Suite 203B
Westborough, MA 01581
Tel: 508-366-5773

www.ancientpathweb.com

Name _____

SKIN & HAIR

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of Hair
☐ Change in Hair or Skin Texture ☐ Other Problem

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 Bleed ☐ Recurrent Sore Throat ☐ Grinding Teeth ☐ Facial Pain
☐ Sores on Lips or Tongue ☐ Teeth Problem ☐ Jaw Clicks ☐ Headache (where, when?)
☐ Other Problem

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
☐ Other Heart or Blood Vessel Problem

RESPIRATORY

☐ Cough ☐ Coughing Blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Pain with a Deep Breath ☐ Difficulty in Breathing When Lying Down
☐ Production of Phlegm (what color?) ☐ Other Lung Problem

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Gas ☐ Belching ☐ Black Stools ☐ Blood in Stools
☐ Indigestion ☐ Bad Breath ☐ Rectal Pain ☐ Hemorrhoids
☐ Abdominal Pain or Cramps ☐ Chronic Laxative Use ☐ Poor Appetite
☐ Other Stomach or Intestine Problem

Ancient Path
Acupuncture and Herbs

394 Lowell Street, Suite 16
Lexington, MA 02420
Tel: 781-863-0066
Fax: 781-357-1911

Acupuncture & Herbal Clinic
of Westborough

33 Lyman Street, Suite 203B
Westborough, MA 01581
Tel: 508-366-5773

www.ancientpathweb.com

GENITO-URINARY

☐ How Many Times per Day Do You Urinate? ☐ Pain upon Urination ☐ Blood in Urine
☐ Urgency to Urinate ☐ Unable to Hold Urine ☐ Kidney Stones ☐ Decrease in Urine Flow
☐ Impotence ☐ Sore on Genitals ☐ Wake up to Urination (how often?)
☐ Particular Color to Your Urine (what color?) ☐ Other Genital or Urinary System Problem

MUSCULOSKELETAL

☐ Neck Pain ☐ Muscle Pain ☐ Knee Pain ☐ Back Pain
☐ Muscle Weakness ☐ Foot / Ankle Pain ☐ Hand / Wrist Pain ☐ Shoulder Pain
☐ Hip Pain ☐ Other Joint or Bone Problem

REPRODUCTIVE AND GYNECOLOGIC

# of Pregnancies _____ # of Live Birth _____ # of Premature Birth _____ # of Miscarriage _____
# of Abortion _____ ☐ Vaginal Discharge ☐ Menstrual Clots ☐ Breast Lumps
☐ Unusual Periods (heavy, light, etc.) ☐ Spotting or Pain between Periods
☐ Menstrual Pain ☐ Irregular Periods ☐ Menopause (age _____) Age of 1st Menses _____
Date of Last Period _____ # of Days Period Lasts _____ # of Days between Periods _____
Date of Last Pap _____ Results: _____
Do you notice any change in body/psyche prior to period? If yes, please describe it.

Do you practice birth control? What type and for how long?

Is there any chance that you are pregnant now?

NEUROPSYCHOLOGICAL

☐ Nausea ☐ Lack of Coordination ☐ Loss of Balance ☐ Areas of Numbness
☐ Depression ☐ Poor Memory ☐ Concussion ☐ Anxiety
☐ Easily Susceptible to Stress ☐ Bad Temper ☐ Tremors
Have you ever been treated for emotional problems? (when? What?)
Have you ever considered or attempted suicide?
Any other neurological or psychological problem?

COMMENTS *Please tell us any other problems you would like to discuss.*
