Brookline Community Acupuncture

1354A Beacon Street, Beacon Way, Brookline, MA 617-879-9992
www.brooklinecommunityacupuncture.com

Please complete this Health-History Form. You may email it back to the clinic (bcacup@gmail.com) or print it out and bring it with you to your appointment. Thank You.

Please leave blank for acupuncturist's notes
Click or tap here to enter text.

Health-History Form

Name: Date:

Address: City/State/Zip:

Phone (day): (evening):

Email: Date of Birth:

Occupation:

Emergency Contact (name and phone):

Please complete this questionnaire as thoroughly as possible. All of your answers will be held in confidence within lawful limits. Print all information and indicate areas of confusion with a question mark. Please leave the right-hand columns blank. Thank you.

Please list the conditions you wish to be treated:

1)

2)

3)

4)

5)

Please list any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking:

Name	Dosage/Amount	Purpose

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Current Health (check any that apply):

Temperature: Fever ☐ Chills ☐ Night sweats ☐ Spontaneous Sweats ☐
Hot Flashes ☐
Do you tend to feel: Warmer than others ☐ Cooler than others ☐

Thirst: Do you tend to be thirsty? Yes ☐ No ☐

Temperature drinks you prefer: warm ☐ room temperature ☐ cool ☐
cold / iced ☐

Digestion: Changes in Appetite ☐ Nausea ☐ Vomiting ☐ Abdominal Pain ☐ Gas ☐ Heartburn ☐ Belching ☐ Other _____

Bowel movements: Frequency: times per day: Choose an item. times per week Choose an item.
Formed ☐ Loose ☐ Liquid (diarrhea) ☐ Difficult to pass ☐
Incomplete ☐

Urination: Color: Dark yellow ☐ Light yellow ☐ Clear ☐
Amount: Scanty ☐ Copious ☐
Urgent ☐ Frequent ☐ Painful ☐ Night-time ☐

Breathing: Cough ☐ Wheezing ☐ Shortness of Breath☐ Painful ☐
Other

Head, Eye, Ear, Nose, and Throat:
Headaches: Location: Frontal ☐ Sides ☐ Back ☐ Top ☐
Quality: dull and nagging ☐ Intense ☐ Sharp ☐
Eyes: Pain/Strain ☐ Tearing ☐ Dryness ☐
Ears: Ringing ☐ Earaches ☐
Sinus Congestion ☐ Nose Bleeds ☐ Frequent Sore Throats☐
TMJ/Jaw Problems ☐ Other

Cardiovascular: High Blood Pressure ☐ Cold Extremities ☐ Palpitations ☐
Chest Pain ☐ Edema ☐
Swelling of Ankles ☐ Stroke ☐ Heart Murmurs ☐
Do you have a pacemaker? Yes ☐ No ☐ Other

Sleep: Hours per night: Choose an item.. How long does it usually take you to fall asleep? Choose an item.
Insomnia ☐ Constant sleepiness☐ Frequent vivid dreams ☐
Other

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Mental State: Irritability ☐ Anger ☐ Anxiety ☐ Depression ☐ Mood Swings ☐ Other

Energy: Fatigue ☐ Hyperactivity ☐

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Click here to enter text.

Immunity: Slow Wound Healing ☐ Chronic Infections ☐ Frequent colds ☐ Allergies ☐ Do you have reduced immunity (such as HIV/AIDS, Hepatitis C, scleroderma, or vitiligo) or are you receiving any treatments that may affect your immunity (such as chemotherapy)? Yes ☐ No ☐ Describe
Other

Reproductive: Erectile Dysfunction ☐ Premature ejaculation ☐ Lack of interest in sex ☐ Penile Discharge ☐ Enlarged Prostrate ☐ Testicular Pain/Swelling ☐
Other:

Reproductive: Irregular Cycles ☐ Nipple Discharge ☐ Heavy Flow ☐ Vaginal Discharge☐ (describe) Breast tenderness before period ☐ Mood fluctuations before period ☐ Painful Periods ☐ Bleeding Between Periods ☐
Lack of interest in sex ☐ Other

Menstrual/Birthing History: Age at first Menses: Length of Cycle: # of Days of Menses: Total # of Pregnancies: Live Births: Age at Onset of Menopause:
Are you pregnant? Yes ☐ No ☐ If yes, where are you in your pregnancy and what is your due date?

Neurologic: Dizziness ☐ Loss of Balance ☐ Paralysis ☐ Seizures/Epilepsy ☐ Numbness/Tingling ☐
Other:

Skin: Rashes ☐ Hives ☐ Acne ☐ Eczema ☐ Sores/Wounds ☐ Location/Other:

Surgeries: 1. date:
2. date:
3. date:
4. date:

Do you have any other concerns that you would like to discuss?

Have you had acupuncture before? Yes ☐ No ☐ Do you have any special sensitivities to needling? Describe:

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For Practitioner

Pulse:

Tongue:

Observations:

1st Treatment:

Tx plan:

Practitioner Name: