



www.integrativefamilyhealth.com - 617.840.9868

New Patient Health History

Name:	Date:	Date of Birth:
Gender:	Height:	Weight:
Marital Status:	Emergency Contact : Emergency Phone:	
Address:		
Day Phone:	Evening Phone:	
Email:	Occupation:	
Physician:	Physician Phone:	
Physician Address:		
Referred by:		

Have you had Acupuncture or Asian Medicine before: YES No
What is your main complaint:
When did this problem begin?
Does it interfere with daily activities like work, sleep, exercise, sex?
Do you have a western medical diagnosis? If so, what is it?
What other treatments have you tried?
PAST MEDICAL HISTORY (please include date) YOU: Significant Illnesses (circle all applicable to you) cancer diabetes hepatitis high blood pressure heart disease

Please indicate any painful or tight areas, or areas of altered sensation by circling it.

Front

Back



Please check any that apply to your health (in the last year):

<p>General:</p> <input type="checkbox"/> Fevers <input type="checkbox"/> Strong thirst <input type="checkbox"/> Sweat Easily <input type="checkbox"/> Night Sweats	<input type="checkbox"/> Peculiar tastes/smells <input type="checkbox"/> Cravings <input type="checkbox"/> Change in appetite <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Low Libido	<input type="checkbox"/> Sudden energy drop <input type="checkbox"/> Chills <input type="checkbox"/> Bleed/bruise easily <input type="checkbox"/> Poor sleep <input type="checkbox"/> Fatigue
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<p>Hair & Skin:</p> <input type="checkbox"/> Itching <input type="checkbox"/> Dandruff <input type="checkbox"/> Other:	<input type="checkbox"/> Ulcerations <input type="checkbox"/> Eczema <input type="checkbox"/> Loss of hair	<input type="checkbox"/> Hives <input type="checkbox"/> Pimples <input type="checkbox"/> Moles <input type="checkbox"/> Rashes
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<p>Head Eyes Ears Nose Throat:</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Glasses <input type="checkbox"/> Poor vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Sinus issues <input type="checkbox"/> Headaches	<input type="checkbox"/> Concussions <input type="checkbox"/> Eye Strain <input type="checkbox"/> Night Blindness <input type="checkbox"/> Poor hearing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Facial pain <input type="checkbox"/> Jaw clicks <input type="checkbox"/> Migraines	<input type="checkbox"/> Eye pain <input type="checkbox"/> Color blindness <input type="checkbox"/> Earaches <input type="checkbox"/> Spots in vision <input type="checkbox"/> Sore throats <input type="checkbox"/> Mouth/lip sores <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Teeth issues
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Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> Coughing blood <input type="checkbox"/> Bronchitis <input type="checkbox"/> Phelgm – color?	<input type="checkbox"/> Asthma <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Pnuemonia	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Pain with breathing <input type="checkbox"/> Other:
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Cardiovascular: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Fainting <input type="checkbox"/> Cold hands/feet <input type="checkbox"/> Swelling of feet <input type="checkbox"/> Swelling of hands <input type="checkbox"/> Varicose veins	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Phlebitis <input type="checkbox"/> Peripheral Arterial Sclerosis <input type="checkbox"/> Other:
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Gastrointestinal: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Indigestion <input type="checkbox"/> Gas <input type="checkbox"/> Belching	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Black stools <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Rectal Pain <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Bad Breath <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Other:
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Urinary: <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urgent urination <input type="checkbox"/> Unable to hold urine <input type="checkbox"/> Night time urination	<input type="checkbox"/> Pain with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Decreased flow	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Color? <input type="checkbox"/> Other:
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Musculoskeletal: <input type="checkbox"/> Neck pain <input type="checkbox"/> Should pain <input type="checkbox"/> Back pain	<input type="checkbox"/> Hand/wrist pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain	<input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Other:
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Neurological: <input type="checkbox"/> Seizures <input type="checkbox"/> Strokes <input type="checkbox"/> Concussion	<input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of balance <input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Areas of Numbness <input type="checkbox"/> Poor memory <input type="checkbox"/> Tremors <input type="checkbox"/> Other:
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Psychological: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Fear	Have you ever been treated for emotional problems?	Have you ever considered or attempted suicide?
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Male Reproductive: <input type="checkbox"/> Impotence <input type="checkbox"/> Prostatitis <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Benign Prostatic <input type="checkbox"/> Testicular pain/injury	<input type="checkbox"/> Premature Ejaculation <input type="checkbox"/> Spermatorrhea <input type="checkbox"/> Low sperm count <input type="checkbox"/> Low motility <input type="checkbox"/> Hypertrophy	<input type="checkbox"/> Testicular cancer <input type="checkbox"/> Sores on genitals <input type="checkbox"/> STDs <input type="checkbox"/> Other:
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Female Reproductive: Are you pregnant? Y N Is it possible you are pregnant? Y N Age of first menses: Duration of menses: Time between menses: <input type="checkbox"/> Irregular periods <input type="checkbox"/> Painful Periods <input type="checkbox"/> Heavy flow <input type="checkbox"/> Light flow <input type="checkbox"/> Clots	Pregnancies: # Live births: # Premature births: # Miscarriages: # Abortions: # <input type="checkbox"/> Infertility <input type="checkbox"/> Western Fertility Tx <input type="checkbox"/> Birth Control What kind?	<input type="checkbox"/> Menopause <input type="checkbox"/> Last PAP <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Breast lumps <input type="checkbox"/> Sores on genitals <input type="checkbox"/> STDs <input type="checkbox"/> Changes in body or psyche with menses What kind? <input type="checkbox"/> Other:
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Thank you for filling out this form. It will help us better serve your needs.
 Please describe any other information you find important to your health and wellness:
