

FirstHealth OF ANDOVER PC

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PATIENT INFORMATION

Today's Date: _____
Name: _____ SS#: _____ / _____ / _____
Address: _____
Street City Zipcode
Residential phone: _____ Business phone: _____
Cell phone: _____ Email address: _____
Date of birth: _____ / _____ / _____ Age: _____ Weight: _____ Height: _____
mo day year
Place of birth: _____
Marital status: Single _____ Married _____ Separated _____ Divorced _____ Number of children _____
Employer: _____
Occupation: _____ Years on job: _____
Insurance company: _____ Policy number: _____
Primary care physician: _____ Phone number: _____
Referred by: _____



Chief health concern: _____

How long ago did this problem begin? _____
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____
Have you been given a diagnosis for this problem? _____
If yes, what? _____
Names of drugs, medicines, or supplements that you are now taking: _____

Therapies that you have tried in the past for this problem: _____

Are you currently involved in any other therapies for this problem? _____
If yes, which? _____

Is this your first experience with acupuncture? yes _____ no _____



MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> pneumonia | <input type="checkbox"/> blood transfusion |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> anemia | <input type="checkbox"/> bleeding disorder |
| <input type="checkbox"/> jaundice | <input type="checkbox"/> hepatitis | <input type="checkbox"/> significant trauma |
| <input type="checkbox"/> ulcer | <input type="checkbox"/> arthritis | <input type="checkbox"/> thyroid disorder |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> cancer | <input type="checkbox"/> glaucoma |
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> tumor | <input type="checkbox"/> surgery |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> kidney/bladder concerns | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> sexually transmitted disease | | |
- allergic reactions (*foods, medicines, chemicals, etc.*): _____
- significant trauma (*date, description*): _____
- birth history (*prolonged labor, forceps delivery, etc.*): _____
- any other disorders not listed above: _____
-



HABITS AND LIFESTYLE

Describe your daily exercise: _____

Do you smoke? yes _____ no _____ If yes, for how long? _____ # of cigarettes per day: _____

Do you consume alcohol? yes _____ no _____ If yes, number of drinks per week: _____

Do you consume caffeinated tea, coffee, cola? yes _____ no _____ If yes, how often: _____

Do you take recreational drugs? yes _____ no _____ If yes, how often: _____

Do you consume sweets? yes _____ no _____ If yes, how often: _____

What are your hobbies? _____

How do you unwind from stress? _____

Are you exposed to chemicals on a daily basis? _____

Are you exposed to second-hand smoke? _____

Please describe your daily diet and the approximate times you eat each meal:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Time you go to bed: _____ Time you get up: _____ Amount of sleep: _____

Any other concerns not listed above? _____



FAMILY MEDICAL HISTORY

- cancer
- diabetes
- kidney stones
- alcoholism
- heart disease
- high blood pressure
- tumor
- cigarette smoking
- arthritis
- allergies
- surgery

Any other concerns not listed above? _____



PERSONAL MEDICAL HISTORY

(PLEASE PLACE AN X BESIDE THE SYMPTOM(S) YOU'VE EXPERIENCED IN THE LAST THREE MONTHS)

GENERAL

- poor appetite
- fevers
- sweat easily
- localized weakness
- bleed or bruise easily
- peculiar tastes or smells
- poor sleeping
- chills
- sudden energy drop (what time?)
- poor balance
- weight loss
- strong thirst (hot or cold drinks)
- fatigue
- night sweats
- food cravings
- change in appetite
- weight gain
- tremors

Any other concerns not listed above? _____

SKIN AND HAIR

- rashes
- itching
- dandruff
- change in hair or skin texture
- ulcerations
- eczema
- hair loss
- hives
- acne
- recent moles

Any other concerns not listed above? _____

HEAD, EYES, EARS, NOSE, AND THROAT

- dizziness
- glasses
- poor vision
- spots in front of eyes
- ringing in the ears
- sinus problems
- grinding of teeth
- teeth problems
- concussions
- eyestrain
- night blindness
- blurry vision
- poor hearing
- recurrent sore throats
- sores on lips or tongue
- jaw clicks
- migraines
- eye pain
- color blindness
- cataracts
- ear aches
- nosebleeds
- facial pain

Headaches (*where and when?*) _____

Any other concerns not listed above? _____

CARDIOVASCULAR

- | | | |
|--|--|---|
| <input type="checkbox"/> high-blood pressure | <input type="checkbox"/> low-blood pressure | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> cold hands and feet | <input type="checkbox"/> fainting |
| <input type="checkbox"/> swelling of the hands | <input type="checkbox"/> swelling of the feet | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> phlebitis | <input type="checkbox"/> difficulty in breathing | <input type="checkbox"/> varicose veins |

Any other heart or blood vessel concerns? _____

RESPIRATORY

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> cough | <input type="checkbox"/> coughing blood | <input type="checkbox"/> asthma |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> pain with a deep breath | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> phlegm (<i>what color?</i>) _____ | | |

Any other concerns not listed above? _____

GASTROINTESTINAL

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> constipation | <input type="checkbox"/> gas | <input type="checkbox"/> belching |
| <input type="checkbox"/> black stools | <input type="checkbox"/> blood in the stools | <input type="checkbox"/> white stools |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> bad breath | <input type="checkbox"/> rectal pain |
| <input type="checkbox"/> chronic laxative use | <input type="checkbox"/> abdominal pain or cramping | <input type="checkbox"/> hemorrhoids |

Any other concerns not listed above? _____

GENITO-URINARY

- | | | |
|---|---|---|
| <input type="checkbox"/> pain on urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> blood in the urine |
| <input type="checkbox"/> urgency to urinate | <input type="checkbox"/> unable to hold urine | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> decrease in flow | <input type="checkbox"/> sores on genitals | |

Do you wake up to urinate (*how often*)? _____

Any other concerns not listed above? _____

MEN

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> weak urine stream | <input type="checkbox"/> prostate trouble | <input type="checkbox"/> impotency |
| <input type="checkbox"/> discharge from penis | <input type="checkbox"/> painful or swollen testes | |

Any other concerns not listed above? _____

WOMEN

- | | | |
|--|--|--|
| <input type="checkbox"/> PAINFUL MENSES | <input type="checkbox"/> CLOTS | <input type="checkbox"/> HOT FLASHES |
| <input type="checkbox"/> BREAST LUMPS OR DISCHARGE | <input type="checkbox"/> VAGINAL DISCHARGE | <input type="checkbox"/> VAGINAL SORES |

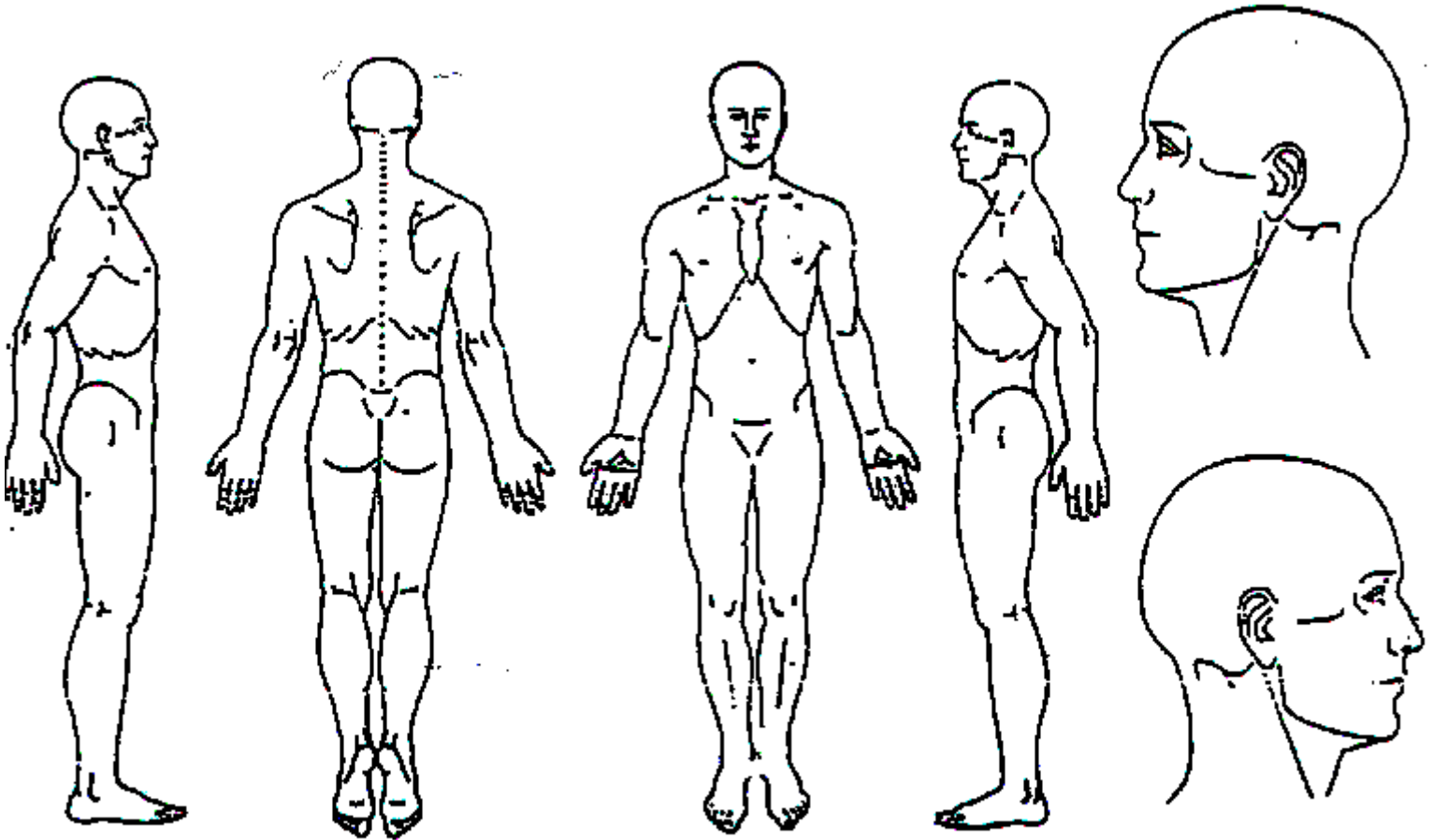
Trouble with menses (*please explain*): _____

Description of pain: _____

When does it get better? _____

When does it get worse? _____

Please indicate the location of your pain on the figures below:



FIRSTHEALTH OF ANDOVER'S MISSION STATEMENT

FirstHealth of Andover was created to bring accomplished practitioners of complementary/ alternative medicine to guide, teach, and assist the members of our community with their health concerns. Motivating patients' interest and revitalizing their ability to heal are at the center of our shared philosophy. We help you maximize the body's potential to heal, discover hidden possibilities for wellness, and enjoy the benefits that hope and balance can bring to life.

FirstHealth believes that by inspiring others to lead their own health team, the best combination of health care and self care will be achieved.