

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

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> cancer | <input type="checkbox"/> heart disease | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> allergies |
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> tumor | <input type="checkbox"/> surgery |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> cigarette smoking | |

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

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

Any other concerns not listed above? _____

SKIN AND HAIR

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> rashes | <input type="checkbox"/> ulcerations | <input type="checkbox"/> hives |
| <input type="checkbox"/> itching | <input type="checkbox"/> eczema | <input type="checkbox"/> acne |
| <input type="checkbox"/> dandruff | <input type="checkbox"/> hair loss | <input type="checkbox"/> recent moles |
| <input type="checkbox"/> change in hair or skin texture | | |

Any other concerns not listed above? _____

HEAD, EYES, EARS, NOSE, AND THROAT

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

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? _____

PAIN

Are you in any pain? _____

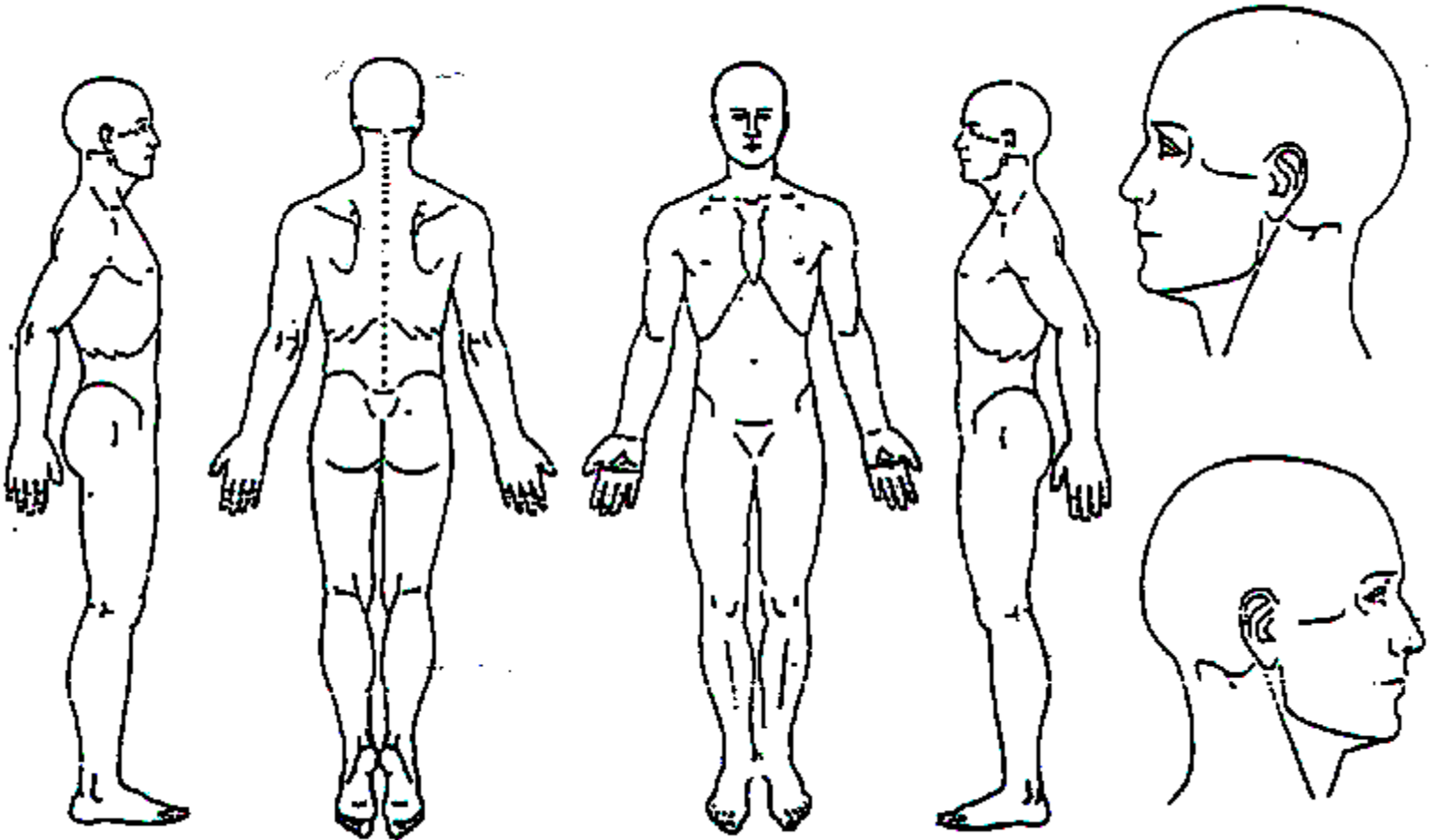
Location of pain: _____

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.