

# Northport Wellness Acupuncture & Massage Therapy

## HISTORY QUESTIONNAIRE

NOTE: Many factors must be considered in designing a complete health-building program. Treating the whole person requires attention to all symptoms and conditions. Often minor symptoms are major clues to delicate biochemical, energetic or somatic imbalances. Please complete the questionnaire as carefully as you can. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME \_\_\_\_\_ DATE \_\_\_\_\_ CASE NO \_\_\_\_\_  
ADDRESS \_\_\_\_\_ RES. PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ BUS. PHONE \_\_\_\_\_  
PRIMARY CARE PHYSICIAN & PHONE \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ REFERRED BY: \_\_\_\_\_  
AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  M  F  M  S  D  W  SPOUSE  CHILD

Is your condition due to  an accident  an illness  Other \_\_\_\_\_  
Did your accident occur while at work?  Yes  No When \_\_\_\_\_  
Were you involved in an automobile accident?  Yes  No When \_\_\_\_\_  
STATE your present complaint, injury or illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did it begin? (Date) \_\_\_\_\_ Describe what caused it: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What makes it better? \_\_\_\_\_  
What makes it worse? \_\_\_\_\_  
Is it getting worse?  Yes  No Does it interfere with:  Work  Sleep  Daily Routine  Other  
Explain: \_\_\_\_\_  
Who have you previously consulted about your present problems? \_\_\_\_\_  
\_\_\_\_\_

Secondary Complaints: \_\_\_\_\_  
Previous Medical Care: \_\_\_\_\_  
Operations: Please indicate all surgeries, type and year \_\_\_\_\_  
\_\_\_\_\_

Have you ever been advised to have any surgery which was not done? \_\_\_\_\_  
Have you been hospitalized for anything other than surgery? \_\_\_\_\_

TREATMENT FOR OTHER CONDITIONS: \_\_\_\_\_  
\_\_\_\_\_

**PERSONAL HISTORY:** Have you ever had/do you currently have:  
 Scarlet Fever  Jaundice  Rheumatic Fever  Gonorrhea/Syphilis  Pneumonia  Anemia  
 Rectal Disease  Gallbladder Disease  Pleurisy  Epilepsy  Bladder Disease  Diabetes  
 Polio/Meningitis  Nephritis  Cancer  Nervous Breakdown  Food/Drug Poisoning  
 TB/Angina  Hay Fever/Asthma  Boils/Infections  Heart Disease  Hepatitis  Alcoholism  
 High Blood Pressure  Miscarriage  Mental disorder  Drug problem  A.I.D.S.

**FAMILY HISTORY:** Has your father or mother ever had:  
 Cancer  Stroke  Scoliosis  Kidney Disease  Glaucoma  TB  Epilepsy  Diabetes  
 Mental Disorder  Heart Trouble  Asthma  Ulcers  Arthritis  Alcoholism  
 High Blood Pressure  Drug problem  Allergies  Other \_\_\_\_\_  
Is there any familial disease tendency of which you are aware: \_\_\_\_\_

**INJURIES:** (Auto accidents, falls, etc.) \_\_\_\_\_  
 Broken Bones  Concussion or Head Injury  Dislocations  Sprains  Loss of Consciousness

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## CURRENT AND FORMER CONDITIONS

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Underline current conditions. Put a check mark in the box for former conditions.  
State duration, frequency, intensity and pain in the space beside current symptoms.**

### GENERAL SYMPTOMS

- Tremors
- Headache
- Fever
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Depression
- Loss of weight
- Forgetfulness
- Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees, or feet
- Confusion
- Auto Immune Deficiency
- Paralysis

### EYES, EARS, NOSE AND THROAT

- Failing vision
- Near sighted
- Eye pain
- Eye strain
- Cross eyed
- Eye inflammation
- Glaucoma
- Deafness
- Earache
- Loss of hearing
- Ear discharge
- Ear noises
- Nose bleeds
- Nasal obstruction
- Nasal drainage
- Loss of smell
- Sinus infection
- Hay fever
- Allergies
- Sore throat
- Hoarseness
- Difficult speech
- Difficult swallowing
- Loss of taste
- Change in tastes
- Dental decay
- Gum troubles
- Tonsillitis
- Asthma
- Frequent colds
- Enlarged thyroid
- Enlarged glands

### SKIN

- Skin eruptions
- Clammy skin
- Dryness
- Bruises easily
- Boils
- Rashes
- Sensitive skin
- Hives or allergy

### RESPIRATORY

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing
- Wheezing

### CARDIOVASCULAR

- Rapid beating heart
- Slow beating heart
- Irregular beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous heart stroke
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke
- Varicose veins

### MUSCLE AND JOINT

- Stiff neck
- Pain between shoulders
- Backache
- Painful tail bone
- Foot trouble
- Hernia
- Spinal curvature
- Faulty posture
- Swollen joints
- Stiff joints
- Painful joints
- Arthritis
- Sore muscles
- Weak muscles
- Walking problems
- Sciatica

### GENITOURINARY

- Frequent urination
- Scanty urine
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection or stones

- Bed wetting
- Inability to control urine
- Prostrate trouble
- Bladder trouble
- Foul smelling urine
- Discolored urine

### GASTROINTESTINAL

- Poor appetite
- Excessive hunger
- Difficult chewing
- Belching or gas
- Nausea
- Gas
- Vomiting
- Vomiting of blood
- Pain over stomach
- Distention of abdomen
- Constipation
- Diarrhea
- Black stool
- Blood in stool
- Colon trouble
- Hemorrhoids (Piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis
- Weight trouble

### FEMALE

- Painful menstrual periods
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Vaginal pain
- Congested breast
- Breast pain
- Lumps in breast
- Menopausal symptoms
- Abnormal bleeding
- Reduced sexual energy
- Pregnancy
- Pregnancy complications

### MALE

- Pain associated with genitals
- Reduced sexual energies
- Premature ejaculation
- Seminal emission
- Impotence
- Discharges

# Northport Wellness Acupuncture & Massage Therapy

## HABITS, DIET, MEDICINES, ALLERGIES

Name: \_\_\_\_\_ Date \_\_\_\_\_

LAST PHYSICAL: Date \_\_\_\_\_ Practitioner: \_\_\_\_\_ Results: \_\_\_\_\_

**HABITS:** Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy Moderate Light None

- |                          |                          |                          |                          |                 |
|--------------------------|--------------------------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol:        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coffee:         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tea:            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco:        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exercise:       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleep:          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Appetite:       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Energy:         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medication:     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vitamins:       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diet:           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teeth problems: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drugs:          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Salt:           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other:          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stress: _____   |

(Chemical, physical, psychological)

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## AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when.

\_\_\_\_\_

\_\_\_\_\_

**MEDICINES** taken within the last two months (include vitamins, over-the counter drugs, herbs)

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:** (Drugs, chemicals, foods. Type of reaction.)

\_\_\_\_\_

\_\_\_\_\_

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**FEMALES ONLY**

Are you or might you be pregnant?  Yes  No  Maybe If yes, what month? \_\_\_\_\_

What method of birth control do you use? \_\_\_\_\_

Are you experiencing reduced sexual energies?  Yes  No Other difficulties?  Yes  No

Explain: \_\_\_\_\_

Do you have regular PAP tests?  Yes  No How regular? \_\_\_\_\_

**PLEASE CHECK OR EXPLAIN IF APPLICABLE:**

**Menstrual Cycle**

Age started: \_\_\_\_\_

Age stopped: \_\_\_\_\_

- Irregular \_\_\_\_\_
- Painful \_\_\_\_\_
- Excess blood \_\_\_\_\_
- Lack of blood \_\_\_\_\_
- Dark \_\_\_\_\_
- Light \_\_\_\_\_
- Heavy clotting \_\_\_\_\_
- Water retention \_\_\_\_\_
- Painful breast \_\_\_\_\_

**Vaginal Discharge:**

- Liquid \_\_\_\_\_
- Yellow \_\_\_\_\_
- Thick \_\_\_\_\_
- Bad odor \_\_\_\_\_
- White \_\_\_\_\_
- Other \_\_\_\_\_

**Gynecological History or Operations:**

- Ovaries \_\_\_\_\_
- Uterus \_\_\_\_\_
- Tubes \_\_\_\_\_
- Vagina \_\_\_\_\_
- Breast \_\_\_\_\_
- Other \_\_\_\_\_

**Pregnancy:**

Total Number: \_\_\_\_\_

Number of children: \_\_\_\_\_

Number of abortions: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

Complications: \_\_\_\_\_

**MALES ONLY**

**PLEASE CHECK OR EXPLAIN IF APPLICABLE:**

- Reduced sexual energies: \_\_\_\_\_
- Premature ejaculation: \_\_\_\_\_
- Seminal emission: \_\_\_\_\_
- Impotence: \_\_\_\_\_
- Discharges: \_\_\_\_\_
- Pain associated with genitals: \_\_\_\_\_
- Other: \_\_\_\_\_