Cornerstone Acupuncture
& Wellness

15 Ermer Rd Suite 211
Salem, NH 03079

978-479-8431

PATIENT HEALTH HISTORY AND INTAKE FORM

Please help us to provide you with a comprehensive and individualized evaluation by filling out this questionnaire. Mark any check boxes that apply now or in the past. Thank you in advance for assisting us with a thorough intake.

Date Today: _____ Date of Appointment: _____
Patient's Full Legal Name: _____
RESIDENTIAL ADDRESS: Street, City, State, Zip Code: _____
_____
MAILING ADDRESS: Street, City, State, Zip Code: _____
_____
Home Phone: _____Work Phone: _____
Cell Phone: _____Other Phone: _____
Preferred Phone (best way to contact you?): _____
Preferred email contact: (Best email address to use)? _____
Date of Birth: _____Age: _____Gender: _____
Marital Status: _____Height_____Weight_____
Weight Gain or Loss? Y or N
Occupation: _____
Have you ever had acupuncture? Y or N
Emergency Contact Name: _____Emergency Contact Phone: _____
Name of Primary Care Provider:
Primary care provider phone: _____Phone: _____
Address of primary care provider (Practice name, Street, City, State, Zip Code):
_____
Main Complaint:
_____
_____
What makes this problem worse?
_____
_____
What makes this problem better?
_____
_____
Treatments you have tried?

_____

_____

If your primary complaint is pain related: 0 is No Pain and 10 is Go to the Hospital Pain:

What is the highest pain you have experienced in the last 10 days?

0 1 2 3 4 5 6 7 8 9 10

What is the least pain you have experienced in the last 10 days?

0 1 2 3 4 5 6 7 8 9 10

What is the highest pain you have experienced in the last 10 days?

0 1 2 3 4 5 6 7 8 9 10

What level has your pain averaged in the past 10 days?

0 1 2 3 4 5 6 7 8 9 10

Surgeries, hospitalizations or accidents related events?

_____

_____

Significant trauma?

_____

_____

Allergies?

_____

_____

Please list medications taken within the last 2 months

_____

_____

Past Medical History (Check all that apply to you):

☐Cancer ☐Hepatitis ☐High Blood Pressure ☐Infectious Disease ☐Sexually Transmitted Infection
☐Diabetes ☐Heart Disease ☐Emotional Disorder ☐Breathing Problems ☐Autoimmune Disease

Do you smoke? Y or N

Caffeine intake per week?

_____

Alcohol intake per week?

_____

Daily Dietary intake?

_____

Typical foods consumed

_____

_____

_____

Please describe any special diet

_____

_____

_____

Exercise regularly? Please describe

_____

_____

Temperature

☐Tend to feel warmer/cooler than others around you ☐Warm/feverish in afternoon ☐Night sweats ☐Sweats easily ☐Cold hands and feet only

Skin and Hair

☐Rashes ☐Ulcerations ☐Hives ☐Itching ☐Eczema ☐Acne ☐Purpura (bleeding under skin) ☐Hair loss ☐Psoriasis ☐Change in skin or hair texture ☐Dryness ☐Moles ☐Skin cancer ☐Spider veins ☐Bruising

Head

☐Dizziness ☐Concussions ☐Migraines ☐Foggy/cloudy headed ☐Poor concentration/memory

Eye, Ear, Nose and Throat

☐Glasses/lenses ☐Eye pain ☐Color blindness ☐Poor vision ☐Cataracts ☐Blurry vision ☐Eye dryness ☐Eye itching ☐Eye burning ☐Floaters ☐Cataracts ☐Earaches ☐Ringing in ears ☐Poor hearing ☐Sinus problems ☐Nose bleeding ☐Sore throat ☐Grinding teeth/TMJ ☐Facial pain ☐Difficult to swallow ☐Sores on mouth

Cardiovascular

☐High blood pressure ☐Low blood pressure ☐Phelebitis (vein inflammation) ☐Irregular heartbeat ☐Varicose veins ☐Fainting ☐Chest pain ☐Rapid heartbeat or palpitations

Chest

☐Constricted feeling ☐Heavy feeling ☐Rib pain ☐Asthma ☐Difficulty inhaling ☐Difficulty exhaling ☐Cough – dry or productive (please circle) ☐History of bronchitis or TB

Digestion

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Gas ☐Bloating ☐Belching ☐Indigestion ☐Acid reflux ☐Abdominal pain ☐Lack of appetite ☐Excess appetite ☐Rectal pain ☐Hemorrhoids ☐Parasites ☐Chronic laxative use ☐Strong smelling gas or stool

Bowel Movement (number per day or week): _____

Genital and Urinary

☐Painful urination ☐Frequent urination ☐Blood in urine ☐Cloudy urine ☐Urgent urination ☐Cannot hold urine ☐Dribbling ☐Pause of flow ☐Incomplete urine ☐Frequent UTI ☐Genital pain ☐Genital itching ☐Genital rashes ☐Sexually transmitted infection ☐Kidney stones

Sleep

☐Difficulty falling asleep ☐Difficulty staying asleep ☐Dream disturbed sleep

Energy

Indicate energy level

0 1 2 3 4 5 6 7 8 9 10

Worse upon waking Y or N

Worse after meals? Y or N

Worse when weather is damp, cold or hot? Y or N

Better with exercise? Y or N

Drops during the day? Y or N

Musculoskeletal

☐Back pain ☐Bone disorder ☐Paralysis ☐Cold hands/feet ☐Hip pain ☐Joint disorder ☐Numbness ☐Swelling ☐Neck pain ☐Muscle weakness ☐Tingling ☐Hernia ☐Shoulder pain ☐Muscle cramping ☐Tremors ☐Spinal curvature ☐Wrist/hand pain ☐Joint sprain ☐Difficulty walking ☐Poor balance

Female Gynecological Disorders and Symptoms

☐Fibroids ☐Ovarian cysts ☐Irregular periods ☐Clots ☐Endometriosis ☐Vaginal discharge ☐Vaginal infections ☐Yeast infections ☐PMS ☐Breast tenderness ☐Breast lumps ☐Hot flashes ☐Fertility problems ☐Anxiety during or before periods

Quality of Periods:

Length of cycle (day 1 to day 1) _____

Number of days of bleeding _____

Date of last menstrual period (LMP) _____

List number of pregnancies, births, miscarriages, premature births, abortions and/or C-sections:

_____

_____

Age of menopause _____

Male Disorders and Symptoms

☐Prostate problems ☐Erectile dysfunction ☐Seminal emission ☐Fertility problems ☐Testical pain ☐Testical swelling ☐Ejaculation problems ☐Discharge

Emotional Disorder and Neuro-psychological

☐Stress ☐Quick to anger ☐Anxiety ☐Post traumatic stress disorder ☐Depression ☐Bipolar ☐Loss of balance ☐Concussion ☐Emotionally induced seizures ☐Lack of coordination