EASTERN HEALTH WAY
ACUPUNCTURE & MASSAGE
697 CAMBRIDGE ST. #202
BRIGHTON, MA 02135
617-309-9901

CONFIDENTIAL PATIENT INFORMATION SHEET

Submit by Email
Print Form

Patient information

Name _____ Date _____

Address _____ City _____ State ____ Zip ____

Phone (H) _____ Phone (M) _____ Email _____

I prefer receive appointment reminder by ☐ Phone ☐ Email ☐ No need to remind me

Height _____ Weight _____ Sex ☐ Male ☐ Female Dominate hand ☐ Left ☐ Right

Date of Birth _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children _____ Age of children _____ Number who live with you ____

Occupation _____ Employer _____

In emergency notify (name) _____ Emergency phone number _____

Primary Care Doctor _____ Last seen _____

How did you hear about EHW Acupuncture: ☐ Web ☐ Brochure ☐ Business Card Referred by _____

Medical History

Reason for your visit here today: _____

How long have you had this condition? _____

Are you being treated for this condition by anyon else? ☐ Yes ☐ No If Yes, who? _____

Has this condition been diagnosed by a MD? ☐ Yes (Diagnosis _____) ☐ No

Have this treatment helped? ☐ Yes ☐ Somewhat ☐ Not much ☐ Not at all

Have you had acupuncture before? ☐ Yes ☐ No Name of Acpuncturist: _____

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly

Medications

Please list the medications and supplement you are currently taking:

Drug/Supplement	Reason for taking	For how long	Dose	Frequency

I am taking coumadin/warfarin ☐ Yes ☐ No I am taking PROZAC ☐ Yes ☐ No I have a pacemaker ☐ Yes ☐ No

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Health inventory

Cardiovascular Condition:

- ☐ Heart Disease
- ☐ A Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:

- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Anxiety
- ☐ Nervousness
- ☐ Alzheimer's
- ☐ Dementia

Energy & Immunity:

- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Respiratory:

- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Musculo-Skeletal:

- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

Head, Eye, Ear, Nose & Throat:

- ☐ Impaired Vision
- ☐ Eye Pain / Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Headaches
- ☐ Ear Infections
- ☐ Sinus problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems
- ☐ Hay Fever

Genito-Urinary Tract:

- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Incontinence

Neurological:

- ☐ Vertigo / dizziness
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy
- ☐ Dyslexia

Gastrointestinal:

- ☐ Stomach Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Epigastric / Abdominal Pain
- ☐ Passing Gas
- ☐ Heart Burn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Leaky Gut Syndrome

Endocrine:

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type
- ☐ Diabetes Type
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

Other:

- ☐ Cancer
  Type: _____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / hives
- ☐ Cold Hand / Feet
- ☐ Hemophilia
- ☐ Thin / Graying Hair

Liver Conditions:

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Men Only:

- ☐ Impotence
- ☐ Vasectomy
  Date: _____
- ☐ Prostate Problems
- ☐ Testicular Pain / Redness / Swelling
- ☐ Low Libido
- ☐ Painful intercourse
- ☐ Excessive Libido
- ☐ Seminal Emissions

Women Only:

Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe Method of Birth Control: _____

Age at first period: _____ Date of last menses: _____ Age at Menopause: _____

Typical length of menses (days): _____ Typical length of cycle (form day 1st to 1st day of menses): _____

Number of pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy ☐ Yes ☐ No Date: _____

Check all that apply: ☐ Low libido ☐ Excessive libido ☐ Painful Intercourse ☐ Clotting ☐ Painful Periods ☐ Heavy Flow

☐ Scanty Flow ☐ Bleeding Between Cycles ☐ Irregular Cycles ☐ Vaginal Discharge ☐ Breast Lumps / Tenderness

☐ Nipple Discharge ☐ Infertility ☐ Menopausal Symptoms ☐ Premenstrual Problems ☐ Endometriosis ☐ Fibroids

☐ Fibrocystic Breasts ☐ Ovarian Cysts ☐ Abnomal Pap Smear

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Lifestyle

Are you vegetarian or vegan? ☐ Yes ☐ No

How would you rate the following areas of your health in the past month:

Energy: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

Digestion: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

Urination: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

Sleep: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

Appetite: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

Diet: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

Exercise: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

Immunity: ☐ Great ☐ Good ☐ Fair ☐ Poor Comment: _____

How would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

Nutrition

List some of your favorite food _____

Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? ☐ Yes ☐ No How often? _____

Do you plan your meal according to the "Four basic food group"? ☐ Yes ☐ No

How many glasses of water do you drink a day? _____ ☐ Filtered ☐ Bottled

DO YOU:

Eat raw fruits or vegetables at least twice a day? ☐ Yes ☐ No

Eat meat or dairy product 2 or more time a day? ☐ Yes ☐ No

Eat green or yellow vegetables at least twice a day? ☐ Yes ☐ No

Eat the same foods almost everyday ☐ Yes ☐ No

Eat frequently between meals? ☐ Yes ☐ No

Eat when you are not hungry? ☐ Yes ☐ No

Chew your food thoroughly before swallowing it? ☐ Yes ☐ No

Eat until you feel full? ☐ Yes ☐ No

Drink juice, milk or other drinks

instead of water when thirsty? ☐ Yes ☐ No

Eat the same foods almost everyday ☐ Yes ☐ No

occasionally go on "crash" diet? ☐ Yes ☐ No

always add salt at the table? ☐ Yes ☐ No

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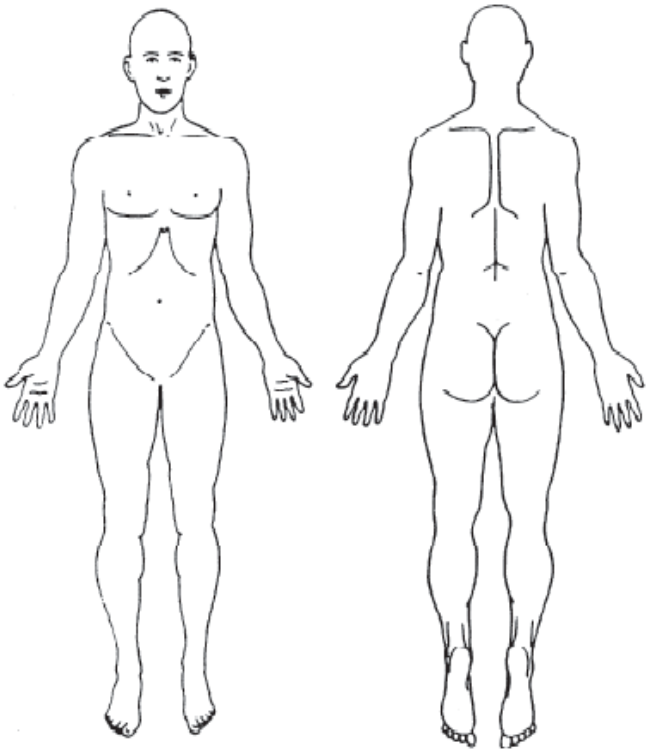
Pain

Please answer the following questions if you have pain

Mark areas of pain on the figures below using this code

+++ Burning
000 Stabbing
-- -- -- Sharp
I I I Constant



Indicate on the diagram on the left areas of pain

Cause of pain? ☐ Injury / Accident ☐ Diease ☐ Unknown

Quality of pain ☐ Dull ☐ Sharp ☐ Stabbing ☐ Sore
☐ Cramping ☐ Burning ☐ Constant ☐ Fixed ☐ Moves about

Did your pain begin ☐ Gradually ☐ Suddenly

Did your have pain ☐ All the time ☐ Sometimes

On a scal of 1-10 (10 being worst) How strong is your pain? _____

No Pain	0	1	2	3	4	5	6	7	8	9	10	EXTREME

What aggravates the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Pressure
☐ Moisture ☐ Massage ☐ Nothing
☐ Other: _____

What helps the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement
☐ Pressure ☐ Moisture ☐ Massage ☐ Nothing
☐ Other: _____

Does your pain interfere with your ☐ Work ☐ Sleep ☐ Daily Routine

Does the pain radiate? ☐ Yes ☐ No Where? _____

Have you had X-ray, CT or MRI before? ☐ Yes ☐ No When? _____

What areas were X-ray (CT or MRI)? _____

List any additional comments you wish to make regarding your condition? _____

_____

_____

Agreement

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify **EasternHealthWay Acupuncture & Massage** 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Signed: _____ Date: _____

Parent / Guardian (if applicable) _____