

AIMA of Nashua Health History

Please help us provide you with a thorough evaluation by taking some time to fill out this questionnaire carefully. All of your answers will be held completely confidential. **Please note current symptoms (last 1-3 months) with an "X" and history of symptoms with an "H".** If you have questions, please ask. If there is anything you wish to bring to our attention that is not addressed on this form, please note it in the "Comments" section. Thank you.

Date: ___ - ___ - _____
Name: _____ Date of Birth: ___ - ___ - _____ Age: _____ Gender: F M
Home phone: _____ Work: _____ Cell: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Email address: _____
Primary Care Provider: _____
Practice Address/Phone: _____
Date of last Physical Exam: _____
May we share this consultation with your health care provider(s)? Yes / No
How did you hear about us? _____
Emergency Contact (First and Last Name): _____
Relation to You: _____ Phone Number(s): _____
Have you been treated with Acupuncture and/or Asian Medicine before? Yes / No
Main reason for your visit today: ___ Preventative care/wellness visit ___ Concern ___ Ongoing problem

How long ago did your concern or problem begin? Please be specific: _____

How does this impact you? What would you like to be able to do that you cannot? _____

Have you been given a diagnosis? If so, what and by whom? _____

What self care or other treatments have you tried and how effective were they? (poor/fair/good):

List one or two goals for this treatment: _____

Past Medical History (Circle all that apply to your history): *Heart / Kidney / Liver / Lung Disease*
Cancer Diabetes Stroke ↑/↓ *Blood Pressure* ↑ *Cholesterol* ↑/↓ *Blood Sugar* *Seizures Asthma Arthritis*
↑/↓ *Thyroid Disease Anxiety Depression Osteopenia Osteoporosis Other:* _____
Hospitalizations or surgeries: _____

Family Medical History (circle all that apply to your family): *Heart / Kidney / Liver / Lung Disease*
Cancer Diabetes Stroke ↑/↓ *Blood Pressure* ↑ *Cholesterol* ↑/↓ *Blood Sugar* *Seizures Asthma Arthritis*
↑/↓ *Thyroid Disease Anxiety Depression Osteopenia Osteoporosis Other:* _____

Do you currently take any prescription medications, supplements or over the counter medications? Please list with dosages (or provide on a separate attachment if necessary): _____

Height: _____ Weight: _____

EENT

__ Poor/blurry vision __ Cataracts __ Glaucoma __ Eye strain __ Night/color blindness __ Floaters/spots __ Eye pain/redness
__ Eye dryness/itching/excessive tearing __ Earaches/infections/pressure __ Dry/itchy ears/↑ wax __ Tinnitus __ Poor hearing
__ Sinus problems __ Sinus infections __ Sinus congestion __ Runny nose __ Post nasal drip __ Nose bleeds __ Jaw problems
__ Clenching/grinding teeth __ Dental surgery or poor dental health __ Bleeding Gums __ Dry mouth/throat __ Sore throat

NEURO

Significant physical trauma (Sports injuries, motor vehicle accidents, falls, broken bones, joint dislocations, head injury):

__ Headaches __ Lightheadedness/dizziness/vertigo __ Concussion __ Head injury __ Loss of consciousness __ Tremors/ tics
__ Seizures __ Poor memory __ Difficulty concentrating __ Other problems with thinking:
__ Peculiar tastes or smells __ Lack of coordination/clumsiness/loss of balance/dropping items __ Paralysis __ Muscle weakness
__ Pain in muscles/joints/bones __ Pain worse with weather: __ Yes __ No Type of weather:
Pain gets better with: Pain gets worse with:
__ Areas of numbness, tingling or abnormal sensation __ Abnormal reflexes __ Facial asymmetry __ Trigeminal neuralgia
__ Range of motion/flexibility loss:

ANS

__ Fevers/Body temp runs warm/hot __ Hands/feet hot or sweating __ Chills/Body temp runs cool/cold __ Hot flashes: day/night
__ Sweat easily __ Night sweating/spontaneous day sweating __ Difficulty with body temp regulation:

IMMUNITY

Do you have any history of or current infectious diseases? __ Measles __ Mumps __ Rubella __ Diphtheria __ Hepatitis
__ Common Cold/Influenza __ Giardiasis __ Meningitis __ CMV __ Herpes virus __ HSV __ HPV __ Cold sores/Herpes
Zoster/Shingles __ Varicella-zoster/ Chickenpox __ Epstein-Barr/Mononucleosis __ HIV/AIDS __ Pertussis/whooping
cough __ Tetanus __ Tuberculosis Do you have any allergies or sensitivities? (Latex, Drugs, Foods, Chemicals, Seasonal):

Do you suffer from frequent illness or chronic infections?
If so, please explain:

SKIN

__ Rashes __ Dryness __ Itching __ Dandruff __ Ulcerations __ Eczema __ Pimples __ Edema __ Rosacea __ Psoriasis __ Acne
__ Hives __ Hair loss __ Recent moles __ Changes in hair or skin texture:

LUNGS/HEART/THORAX

Do you __ bleed or __ bruise easily? __ Shortness of breath __ Bronchitis/pneumonia/emphysema __ Difficulty breathing
__ Pain ÷ deep breath __ Cough with/without phlegm/blood __ Wheezing with breathing __ Subcostal tension __ Fainting
__ Chest pain/pressure/tightness __ Heart palpitations/irregular heartbeat __ Cold hands or feet __ Blood clots __ Poor circulation
__ Swelling of hands or lower extremities __ Varicose veins __ Peripheral vascular disease Other:
BP: / PULSE:

GI/GU:

Appetite Normal/ ↑/ ↓ __ Strong thirst __ Nausea __ Vomiting __ Heart burn __ GERD __ Reflux __ Bad breath __ Gassiness
__ Bloating __ Belching __ Flatulence __ Indigestion __ Abdominal pain/cramps __ Diarrhea __ Constipation __ Alternating
__ Black/clay/abnormal colored stools __ Blood/mucous/undigested food in stools __ Chronic laxative use __ Rectal pain
__ Hemorrhoids __ Urinary urgency/frequency __ Urinary delay/decreased flow __ Night time urination __ Painful urination
__ Urine cloudy/foul odor/dark __ Blood in urine __ Bladder incontinence Urinary frequency:
Bowel movement frequency: Other:

ENERGY

Fatigue Sudden drop during the day at ___ am/ ___ pm Fatigue after eating ___/10 Normal level ___/10 Current

ADL/IADL

Assistance needed with self care/home management/daily living tasks

LIFESTYLE

Food intolerances Restricted diet? Reason/describe: _____

Have you gained or lost weight in the last year? If so, how much? _____

Please describe your typical daily dietary intake. Include breakfast, lunch, dinner and snacks: _____

Cravings: sweet/salty/chocolate/crunchy/other: _____

How much water do you drink per day? _____

Caffeinated coffee/tea/soda do you drink per week/day? _____

Average daily life stress level: Low Low-Moderate Moderate Moderate-High High

Triggers and coping strategies: _____

Experience with relaxation techniques/meditation/visualization exercises: Yes / No If so, was it helpful? Yes / No

Alcohol/recreational drug use/frequency per day/week/month: _____

Tobacco use/amount per day/week: _____

Birth City/State: _____

Marital Status: M/ D/ W/ S Number of children/pets living with you: _____

Occupation: _____ FT/PT/Out of Work/Retired/Homemaker

Hobbies/Interests: _____

Regular exercise program: Yes/No and describe: _____

Spirituality/religious orientation: _____

SLEEP

Not feeling rested upon waking Not enough sleep Difficulty getting to sleep Night-time waking/light sleeper

Physical discomfort at night Dream disturbed sleep Total amount per night: _____ hours

PSYCHOSOCIAL

Propensity for stress/worry/frustration/anger Optimist/Pessimist Introvert/Extrovert Depression Anxiety

Fearfulness Sadness Suicidal ideation History of suicidality Limited supports Good support system

Relationship with spouse/parents/siblings: Good/Fair/Poor Have you had therapy or treatment for stress or emotional

problems? _____ Was it helpful? _____

MALE REPRODUCTIVE

Erectile dysfunction Change in libido Testicular pain/injury Testicular cancer Prostatitis Prostate CA

Benign prostatic hypertrophy Seminal fluid leakage Low sperm count/motility STD's

Other: _____

OB-GYN

Age of first menses: _____ Duration of menses: _____ Time between menses: _____

Irregular periods Painful periods Heavy/light periods Clots in menstrual blood Dark color of menstrual blood

Changes in body/emotions before/during/after menses: headache, breast tenderness/swelling, abdominal cramps, low back

pain, emotional lability Breast lumps Endometriosis Uterine fibroids Urinary tract infections Yeast infections

Abnormal vaginal discharge (amount/color/consistency/odor) STD's Birth control use (please list type and length of use): _____ Date of last menstrual period: _____
 Peri-menopausal Menopausal Post menopausal at age/year: _____ Last PAP/Gyn exam date: _____

Are you pregnant? Yes / No Number of births: _____ Number of pregnancies: _____ Number of premature births: _____
Number of miscarriages: _____ Do you wish to become pregnant? Yes / No If so, when? _____
 Infertility Western fertility treatment Notes: _____

Pregnancy Experience

(Edema/swelling, nausea/vomiting, high blood pressure, headache, dizziness/vertigo, other physiological/emotional issues): _____

Labor and Childbirth

(Method; labor experience/duration/complications): _____

Post Natal Conditions

(Presence of nausea/vomiting, bleeding, chills/fever/sweating, emotional status):
" _____

Reserved for provider use only below this line

Diagnosis:

Treatment Plan: _____

Treatment today: _____

Treatment Goal(s):

- Increase awareness of self care needs
- Maximize independence in self care and health maintenance
- Return to previous level of function
- Decrease level of discomfort to allow for return to prior activities

Other: _____

Referrals: _____

