

# Whole Health Acupuncture and Herbal Medicine

30/50 Forest Falls Drive  
Yarmouth, ME 04096

## Health History Form

Please take time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have questions, please ask.

Name:	_____	Date:	_____
Address:	_____		
City:	_____	State:	_____
		Zip:	_____
Home Phone:	_____	Work Phone:	_____
Mobile Phone:	_____	E-mail:	_____
Date of Birth:	_____	Age:	_____
		Marital Status:	_____
Occupation:	_____	Referred by:	_____
Physician:	_____	Phone:	_____
Physician's Address	_____		
In Emergency Notify	_____	Phone:	_____

**Main Complaint** (symptoms, diagnosis, duration, etc.) \_\_\_\_\_

\_\_\_\_\_

**Significant Trauma** (physical, emotional) & **Surgeries** (please include date of procedure) \_\_\_\_\_

\_\_\_\_\_

**Allergies** (chemical, environmental, food, drugs, etc.) \_\_\_\_\_

\_\_\_\_\_

**Medications/Vitamins/Supplements/Herbs** *please attach an additional page if necessary* \_\_\_\_\_

\_\_\_\_\_

**Birth History** (prolonged labor, forceps delivery, complications, etc.) \_\_\_\_\_

\_\_\_\_\_

**Exercise:** Days per week \_\_\_\_\_ Length of workout \_\_\_\_\_ Type of Activity \_\_\_\_\_

**Typical Diet:** Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

Snacks \_\_\_\_\_ Caffeinated Drinks (what/how many) \_\_\_\_\_ Alcohol per week \_\_\_\_\_

**Personal History** Please check any conditions or symptoms you have or have had.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease         |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia         | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> High Cholesterol      |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> IBS/Diverticulitis    |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease     |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Gastritis/Pancreatitis  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema             |

**Family Medical History** Please check any condition that applies to your immediate family.

- |  |  |                                 |
|--|--|---------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergies     | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
- 

**Please Check if you have had any of these items listed below in the last 3 months.**

**General Symptoms**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Poor Appetite             | <input type="checkbox"/> Poor Sleep          | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Heavy appetite            | <input type="checkbox"/> Dental/gum problems | <input type="checkbox"/> Sweat Easily            | <input type="checkbox"/> Night Sweats        |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Bodily heaviness    | <input type="checkbox"/> Poor Balance            | <input type="checkbox"/> Cold hands or feet  |
| <input type="checkbox"/> Strongly like hot drinks  | <input type="checkbox"/> Weight loss/gain    | <input type="checkbox"/> Peculiar tastes/ smells | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Muscle Weakness/Fatigue   | <input type="checkbox"/> Sudden energy drop  | <input type="checkbox"/> Change in appetite      | <input type="checkbox"/> Bleed/Bruise easily |

**Skin and Hair**

- |   |                                      |  |  |
|---|--------------------------------------|--|--|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching       |
| <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Loss of hair              | <input type="checkbox"/> Recent moles  |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in texture         | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis         | <input type="checkbox"/> Warts       | <input type="checkbox"/> Fungal Infections         |  |

**Head, Eyes, Ears, Nose and Throat**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Eye Strain             | <input type="checkbox"/> Ringing in Ears            | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Facial Pain      |
| <input type="checkbox"/> Eye Pain               | <input type="checkbox"/> Poor Hearing               | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Jaw Clicks/locks |
| <input type="checkbox"/> Color blindness        | <input type="checkbox"/> Earaches                   | <input type="checkbox"/> Grinding teeth        | <input type="checkbox"/> Dizziness        |
| <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Recurrent sore throat/Cold | <input type="checkbox"/> Sores on lips/tongue  | <input type="checkbox"/> Blurred Vision   |
| <input type="checkbox"/> Poor Vision            | <input type="checkbox"/> Dental Problems            | <input type="checkbox"/> Nose bleeds           |   |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Migraines                  | <input type="checkbox"/> Sinus Problems        |   |

**Cardiovascular**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots       | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> High blood Pressure    | <input type="checkbox"/> Varicose/spider veins  | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Spontaneous sweating   | <input type="checkbox"/> Dizziness         |  |
| <input type="checkbox"/> Irregular heart beat   | <input type="checkbox"/> Palpitations at rest   | <input type="checkbox"/> Fainting          |  |

## Respiratory

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Bronchitis       | <input type="checkbox"/> Difficult breathing laying down |
| <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Difficult inhale | <input type="checkbox"/> Production of phlegm            |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Tight sensation in chest  | <input type="checkbox"/> Difficult exhale |  |

## 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 stool        |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Rectal Pain         | <input type="checkbox"/> Mucous in stool       |
| <input type="checkbox"/> Bloating/Edema      | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools        | <input type="checkbox"/> Abdominal pain/Cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux//GERD    | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Excessive appetite  | <input type="checkbox"/> Significant thirst   | <input type="checkbox"/> IBS/Crohn's Disease |  |

## Genito-Urinary

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Pain on urination                                    | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Impotence                 |
| <input type="checkbox"/> Unable to hold urine                                 | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Scanty urine flow  | <input type="checkbox"/> Nocturnal emission        |
| <input type="checkbox"/> Urgent urination                                     | <input type="checkbox"/> Sores on genitals  | <input type="checkbox"/> Copious urine flow | <input type="checkbox"/> Premature ejaculation     |
| <input type="checkbox"/> Burning urination                                    | <input type="checkbox"/> Decreased libido   | <input type="checkbox"/> Prostatitis        | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Urinary tract infection                              | <input type="checkbox"/> Pain in testicles  | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Infections                |
| <input type="checkbox"/> Night urination - How often? _____ What times? _____ |   |   |  |

## Gynecological/Reproductive

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Difficult/Painful intercourse   | <input type="checkbox"/> Endometriosis               | <input type="checkbox"/> Date of last menses _____           |
| <input type="checkbox"/> Vaginal Dryness   | <input type="checkbox"/> Uterine Fibroids            | <input type="checkbox"/> Date of last PAP/Pelvic _____       |
| <input type="checkbox"/> Vaginal sores   | <input type="checkbox"/> Fibrocystic breast tissue   | <input type="checkbox"/> Number of pregnancies _____         |
| <input type="checkbox"/> Vaginal Discharge   | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Infertility   | <input type="checkbox"/> PMS                         | <input type="checkbox"/> Number of live births _____         |
| <input type="checkbox"/> Irregular Menstruation  | <input type="checkbox"/> Painful menstruation        | <input type="checkbox"/> Number of miscarriages _____        |
| <input type="checkbox"/> Ovarian cysts   | <input type="checkbox"/> Age of first menses _____   | <input type="checkbox"/> Number of abortions _____           |
| <input type="checkbox"/> Do you practice birth Control? _____ What type? _____ For how long? _____ |  |  |

## Musculoskeletal

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Knee pain       | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Bursitis      |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Sprains/Strains         | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Hip pain      | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Muscle pain             | <input type="checkbox"/> Tendonitis    |
| <input type="checkbox"/> Back pain     | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Sciatica                | <input type="checkbox"/> Rotator cuff  |

## Neuropsychological

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Nervousness                 | <input type="checkbox"/> Bad temper/irritable         | <input type="checkbox"/> ADD/ADHD          |
| <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Considered/attempted suicide | <input type="checkbox"/> Easily stressed   |
| <input type="checkbox"/> Anxiety/panic attacks | <input type="checkbox"/> Seasonal Affective Disorder | <input type="checkbox"/> Seeing a therapist           | <input type="checkbox"/> Poor memory       |
|  |  |   | <input type="checkbox"/> Areas of numbness |

**On the back of this form please inform us of any other problems you would like to discuss.**