Date:_____

Pax Masssage
146 High Steet
Ipswich, MA 01938

HEALTH HISTORY QUESTIONNAIRE

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held strictly confidential.* If you have any questions, please ask. If there is anything you wish to bring to my attention that is not included in this form, please note it in the "comments" section on the last page. Thank you.

Name:	Date of Birth:	Weight:
Family Physician:_____ Location:_____		Height:
Marital status:	Referred by:	

Have you ever been treated by acupuncture or Oriental medicine before? ☐Yes ☐No
Main problem(s) you would like help with:
How long ago did this problem begin? Please be specific:
To what extent does this problem interfere with daily activities such as work, sleep, sex, etc.?
Have you ever been given a diagnosis for this problem? If so, what?
What kinds of treatment have you tried?

PAST MEDICAL HISTORY (please include date):

Significant Illnesses (please circle all applicable) Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever Thyroid Disease Seizures Venereal Disease Other:
Surgeries
Significant Trauma (auto accidents, falls, breaks, etc.)
Allergies (drugs, chemicals, foods)
Birth History (prolonged delivery, premature, forceps)

Family Medical History: (Please circle all applicable and note which family member was affected.) Cancer Diabetes Hepatitis Heart Disease High Blood Pressure Rheumatic Fever Thyroid Disease Seizures Venereal Disease Other

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)		
Occupation:	Occupational stress (chemical, physical, psychological, etc.)	
Do you have a regular exercise program? If yes, please describe.		
Have you ever been on a restricted diet? If yes, what kind?		
Morning:	**Please describe your average daily diet:** Afternoon:	Evening:
How many packs of cigarettes do you smoke each day?		
How much coffee, tea or cola do you drink per week?		
Please describe any use of drugs for non-medical purposes.		

Please check if you have had any of the following within the last 3 months:

General

☐ Poor Appetite	☐ Poor sleep	☐ Fatigue
☐ Fevers	☐ Chills	☐ Night sweats
☐ Sweat Easily	☐ Tremors	☐ Cravings
☐ Localized Weakness	☐ Poor Balance	☐ Change in appetite
☐ Bleed of bruise easily	☐ Weight Loss	☐ Weight Gain
☐ Peculiar Tastes or smells	☐ Strong thirst	

☐ Energy drops suddenly (what time of day?)

Skin and Hair

☐ Rashes	☐ Ulcerations	☐ Hives
☐ Itching	☐ Eczema	☐ Pimples
☐ Dandruff	☐ Loss of hair	☐ Recent moles

☐ Change in hair or skin texture? (Explain)

☐ Any other hair or skin problems? (Explain)

Cardiovascular

☐ High blood pressure	☐ Low blood pressure	☐ Chest pain
☐ Irregular heartbeat	☐ Dizziness	☐ Fainting
☐ Cold hands or feet	☐ Swelling of hands	☐ Swelling of feet
☐ Blood clots	☐ Phlebitis	☐ Difficulty breathing

☐ Any other heart or blood vessel problems?

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Difficulty breathing while lying down
- ☐ Pain upon deep breathing
- ☐ Production of phlegm? Color?
- ☐ Pneumonia
- ☐ Coughing blood
- ☐ Any other lung problems?

Head, eyes, ears, nose and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor Vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus Problems
- ☐ Grinding Teeth
- ☐ Other teeth problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores or lips, tongue
- ☐ Headaches (Where, when)
- ☐ Any other head or neck problems?

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath (frequent)
- ☐ Abdominal pain or cramps
- ☐ Vomiting
- ☐ Frequent gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Chronic use of laxatives
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Any other problems with your stomach, intestines?

Genito-Urinary

- ☐ Pain upon urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in urine
- ☐ Wake to urinate? How often?
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Any other problems with genito-urinary system?

Reproductive and Gynecologic

- ☐ Pregnancies #:
- ☐ Live Births #:
- ☐ Miscarriages #:
- ☐ Abortions #:
- ☐ Premature Births #:
- ☐ Age at First Menses:
- ☐ Period Btwn Menses
- ☐ Duration of Menses
- ☐ Unusual Character of flow (heavy, light)
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Clots
- ☐ Last Pap
- ☐ Vaginal Discharge
- ☐ Vaginal Sores
- ☐ Breast Lumps
- ☐ Menopause (Age when began?)
- ☐ Changes in Body/Psyche prior to menstruation? Any PMS symptoms?
- ☐ Do you practice birth control? What type? For how long?

Musculoskeletal (*please note left or right if applicable)*

☐ Neck pain	☐ Muscle pain	☐ Knee pain
☐ Back pain (upper, mid, lower?)	☐ Muscle weakness	☐ Foot/ankle pain
☐ Hand/wrist pain	☐ Shoulder pain	☐ Hip pain

☐ Any other joint or bone problems?

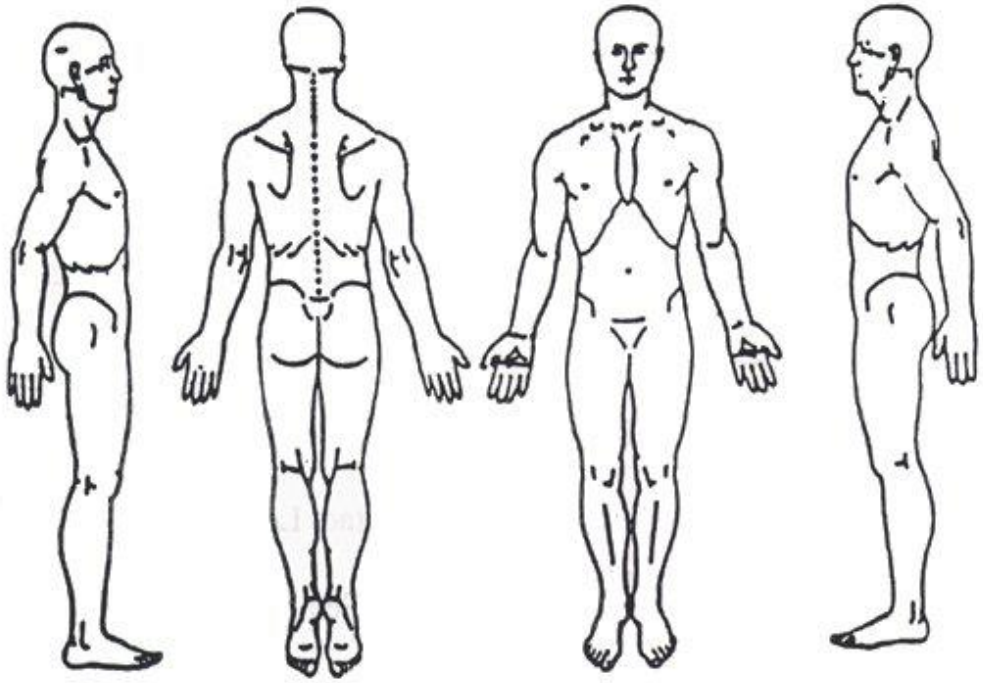
Neuro-psychological

☐ Seizures	☐ Lack of coordination	☐ Anxiety
☐ Concussions	☐ Loss of balance	☐ Easily susceptible to stress
☐ Bad temper	☐ Depression	☐ Poor memory
☐ Dizziness		

☐ Have you ever been treated for emotional problems?

☐ Any other neurological or psychological problems?

Please indicate any painful or distressed body areas by circling the particular area:



COMMENTS:
Please tell me of any other problems that you would like to discuss.

_____
_____
_____
_____
_____