Christine Almeida | Lic. Ac.
Salem, Massachusetts| 617.872.4082

HEALTH HISTORY FORM

Patient Name: _____Date: _____

Street/Box: _____Town _____ State/Zip: _____

Cell _____ Home _____ E-mail _____

DOB: _____ Age: _____ Gender: _____ Height _____ Weight _____

Occupation: _____ Retired: _____ Disabled: _____ Unemployed _____

Emergency Contact Name & Phone Number: _____

How did you hear about this clinic? _____

Reason for Visit/Main Complaint(s):

1.

2.

3.

How long ago did this begin? _____

Have you consulted a physician? _____

Have you been given a diagnosis? If so, what: _____

What other forms of treatment have you tried? _____

Have you tried acupuncture before? _____

<u>Past Personal Medical History of Significant Illnesses</u>:

▢Asthma ▢Allergies ▢Diabetes ▢Cancer ▢Stroke ▢Heart Disease

▢High Blood Pressure ▢Pacemaker ▢Seizures ▢Thyroid Disease ▢Hepatitis

▢HIV ▢Auto Immune Disease ▢Prostate Issues ▢Depression

Significant Trauma, Auto Accidents, Injuries:_____

_____

Hospitalizations/Surgeries & Dates:_____

_____

Allergies: _____

Other Significant Illnesses: _____

Family Medical History:

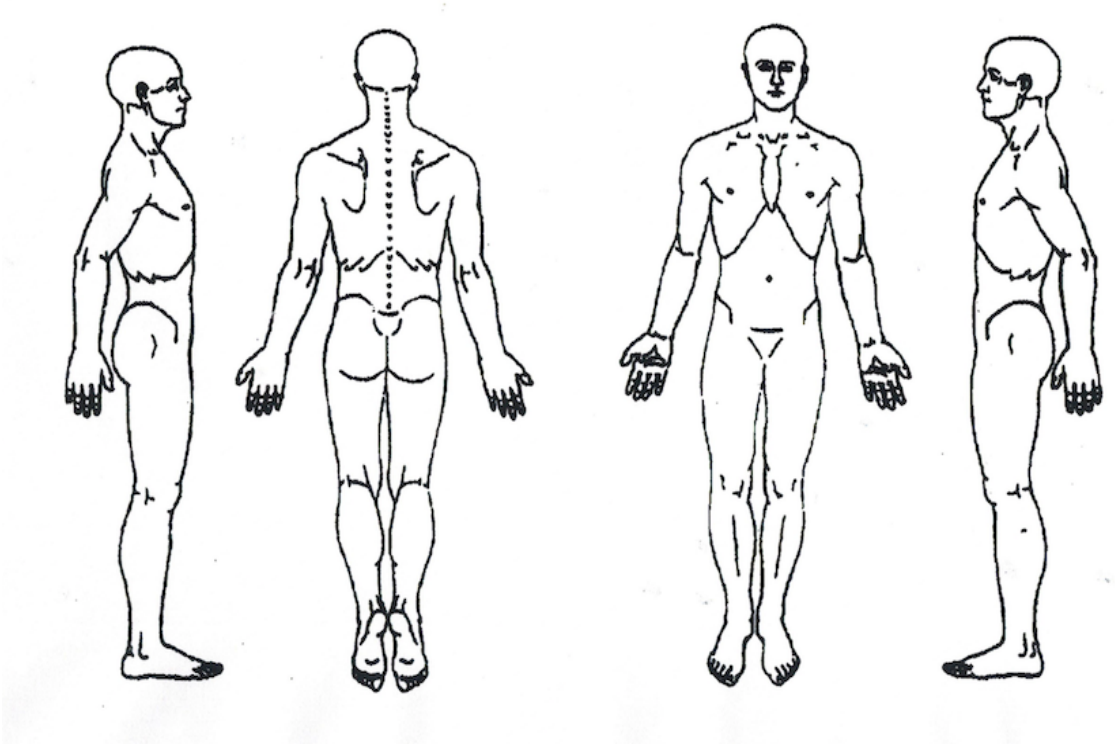
▢Asthma ▢Allergies ▢Diabetes ▢Cancer ▢Stroke ▢Heart Disease

▢High Blood Pressure ▢Pacemaker ▢Seizures ▢Thyroid Disease ▢Hepatitis

▢HIV ▢Auto Immune Disease ▢Prostate Issues ▢Depression

Medications (prescription, OTC, vitamins/supplements, herbs, etc.): Reason:

Please Indicate Areas of Pain:



Average Diet:

Morning | Afternoon | Night

Daily Health Habits:

Do you smoke? Yes/No — If yes, how much?
How much alcohol do you drink in a week?
Describe any use of drugs for non-medical purposes:
How much coffee or tea do you drink in a day?
How much water do you drink in a day?
Do you have a regular exercise program? Yes/No — Describe:
How many hours of sleep per night?

Check any that apply currently or in the last 3 months:

General

▢Fevers	▢Strange Tastes or Smells	▢Poor Sleep
▢Sweats Easily	▢Cravings	▢Fatigue
▢Night Sweats	▢Change in Appetite	▢Sudden Energy Drop
▢Run Warm	▢Weight Loss	▢Bruise or Bleed Easily
▢Run Cold	▢Weight Gain	▢Strong Thirst

Skin & Hair

▢Rashes	▢Ulcerations	▢Hives
▢Itching	▢Acne/Pimples	▢Recent Moles
▢Dandruff	▢Eczema	▢Discoloration
▢Dry Skin	▢Psoriasis	▢Infection
▢Brittle Nails	▢Hair Loss	▢Other:

Head

▢Dizziness	▢Poor Vision	▢Migraines
▢Vertigo	▢Eye Pain	▢Headaches
▢Ringing in Ears	▢Eye Twitching	▢Sinus Congestion
▢Ear Pain	▢Cataracts	▢Sore Throats
▢Ear Blockage	▢Dry Eyes	▢Post Nasal Drip
▢Poor Hearing	▢Spots/Floaters in Vision	▢Nose Bleeds
▢Teeth Problems	▢Poor Night Vision	▢Cloudy/Fogginess
▢Teeth Grinding/Clenching	▢Facial Pain	▢Concussion
▢TMJ	▢Canker Sores/Mouth Ulcers	▢Other:

Cardiovascular

▢Chest Pain/Tightness	▢Fainting	▢Blood Clots
▢Irregular Heartbeat	▢Cold Hands or Feet	▢Palpitations
▢High/Low Blood Pressure	▢Swelling in Limbs	▢Varicose Veins

Respiratory

▢Cough	▢Asthma	▢Phlegm Production
▢Coughing of Blood	▢Difficulty Breathing	▢Pneumonia
▢Bronchitis	▢Wheezing	▢Shortness of Breath

Gastrointestinal

▢Nausea	▢Gas	▢Hemorrhoids
▢Vomiting	▢Belching	▢Blood in Stool
▢Indigestion	▢Diarrhea/Loose Stool	▢Black Stool
▢Acid Reflux/GERD	▢Constipation	▢Poor Appetite
▢Bloating	▢Sluggish Bowel	▢Excessive Appetit
▢Abdominal Distention	▢Abdominal Pain/Cramps	▢Hernia
▢Bleeding Gums	▢Rectal Pain/Burning	▢Laxative Use
▢Bad Breath	▢Undigested Food in Stool	▢Other:

Urinary

▢Frequent Urination	▢Pain with Urination	▢Weak Stream
▢Urgency to Urinate	▢Inability to Empty Bladder	▢Blood in Urine
▢Incontinence	▢Frequent UTIs	▢Kidney Stones
▢Dark Color to Urine	▢Strong Odor to Urine	▢Cloudy Urine
▢Frequent Night Urination	▢Other:	

Male Health

▢Impotence	▢Low Sperm Count	▢Low Libido
▢Premature Ejaculation	▢Low Motility	▢STDs
▢Enlarged Prostate	▢Testicular Pain	▢Other:

Female Health

Are you or is it possible that you are pregnant? Yes/No

Number of Pregnancies: Live Births: Miscarriages: Abortions:

Are you currently using birth control? Yes/No

Age at First Period: Duration of Period: Length of Cycle:

▢Heavy Period	▢Uterine Fibroids	▢Vaginal Discharge
▢Light/Scanty Period	▢Ovarian Cysts	▢STDs
▢Painful Periods	▢Endometriosis	▢Fertility Issues
▢Breast Tenderness	▢Clots in Blood Flow	▢PMS
▢Period Begins with Spotting	▢Frequent Yeast Infections	▢Spotting
▢Hesitant Start to Period	▢Polycystic Ovarian Syndrome	▢Irregular Cycle

Musculoskeletal

▢Neck Pain	▢Hand/Wrist Pain	▢Shoulder Pain
▢Back Pain	▢Foot/Ankle Pain	▢Sciatica
▢Hip Pain	▢Overall Muscle Ache	▢Muscle Weakness
▢Knee Pain	▢Herniated Discs	▢Other:

Neurological

▢Seizures	▢Dizziness/Vertigo	▢Confusion
▢Stroke	▢Loss of Balance	▢Tremors
▢Concussion	▢Areas of Numbness	▢ADD/ADHD
▢Poor Memory	▢Neuropathy/Nerve Pain	▢Poor Coordination
▢Other:		

Emotions

▢Depression	▢Insomnia/Mind Racing	▢Panic Attacks
▢Anxiety	▢Fear/Phobias/Worry	▢Nervousness
▢Anger/Temper	▢Easily Susceptible to Stress	▢Other:

Are you currently being treated for emotional or psychological issues?

Have you ever considered or attempted suicide?

CONSENT TO TREATMENT I hereby authorize Christine Almeida, Lic. Ac. and any licensed acupuncture Contractors of Salem Acupuncture Therapy, primary located at 111 Canal Street, Salem, MA 01970, to administer treatment of acupuncture and other techniques relevant to my diagnosis. I have the right to refuse any form of treatment. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers, and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Treatment may include but is not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using conventional heat lamp or "moxibustion" (burning *Artemesia Vulgaris* herb). With any heat treatment, there may be a risk of burning.
3. Massage technique of *gua sha*. This technique may cause redness on the skin at the site of treatment. Slight bruising and tenderness may persist after the treatment.
4. The placement of suction (vacuum) cups on the skin. These cups may produce a red or purple mark on the skin at the site of cup placement. Slight bruising or tenderness may remain after the treatment.
5. Electrical stimulation of the needles may be used, producing a tapping sensation at the needles' location.
6. The use of press-tacks, press-balls, magnets, intradermal needles, non-insertive needles, laser therapy, ion-pumping (mildly electrical) cords, and other various techniques that can be applied and used in the office, and/or sent home with the patient. There is a possibility that these could cause irritation of the skin.

- I have been informed that I have the right to refuse any form of treatment.
- I understand the nature of the treatment and have been given the opportunity to ask questions pertaining to the treatment.
- I also understand that there is always a possibility of an unexpected complication and the possible aggravation of symptoms existing prior to treatment.
- I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some risks with treatment--including, but not limited to, local bruising, slight bleeding, fainting, temporary pain and discomfort, and nausea. Very rare risks might be a punctured lung and infection.
- I understand that an emotional response to the treatment(s) can occur in some patients. - I do not expect the acupuncturist to be able to anticipate and explain all risks and possible complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.
- I understand that no guarantee can be made concerning the results of

treatment. Signature of Patient or Legal Guardian:

_____

_ Printed Name of Patient: _____ Date

_____

ACUPUNCTURE APPOINTMENT CANCELLATION / NO SHOW POLICY

When you schedule an appointment with Salem Acupuncture Therapy, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact the office as soon as possible. If cancellation is not made 24 hours prior a cancellation fee will apply.

Please acknowledge the Salem Acupuncture Therapy Appointment Cancellation/No Show Policy:

• Effective November 1, 2020 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24-hours notice** will be considered a No Show and charged a $75.00 fee.
• As a courtesy, we send reminder emails and text messages for appointments. If you do not receive a reminder, the above Policy will remain in effect.
• The Policy does not apply to cancellations due to any symptoms seen in COVID-19 patients, but we still need to be notified as soon as possible.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact the office, and a one-time consideration may be given.

I have read and understand the Salem Acupuncture Therapy Cancellation/No Show Policy and agree to its terms.

Signed(patient signature): _____ Date: _____