

Community Acupuncture on Cape Cod
775 Main Street, Suite A West Dennis, MA 02670
508-398-7770 www.acuforall.com
Health History Questionnaire and Registration

PATIENT INFORMATION <i>PLEASE PRINT</i>	CONTACT INFORMATION
Date _____	Home phone _____
Name _____	Work phone _____
Address _____	Other/cell phone _____
City State Zip _____	Email _____
Age _____ Birthdate _____	Another person we may contact if needed:
Occupation _____	Name _____
Primary physician _____	Relationship _____
Physician phone number _____	Home phone _____
How did you hear about us? _____	Work phone _____
_____	_____

HEALTH HISTORY	
<p>What are your primary concerns for coming in for treatment?</p> <p>1- _____</p> <p>2 - _____</p> <p>3 - _____</p> <p>How is your sleep? _____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries.</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives.</p> <p>Diabetes . High blood pressure . Stroke</p> <p>Cancer . Heart disease . Kidney disease</p>	<p>Could you be pregnant? _____</p> <p>Check symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty in focusing <input type="checkbox"/> Dizziness <input type="checkbox"/> Easily startled <input type="checkbox"/> Excessive worry <input type="checkbox"/> Excessive anger <input type="checkbox"/> Excessive fear <input type="checkbox"/> Fatigue/tiredness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep/poor sleep <input type="checkbox"/> Loss or gain of weight <input type="checkbox"/> Nervousness/irritability <input type="checkbox"/> Overwhelmed by life <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Breast lump <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <p>How long has it been since you have had a complete medical exam? _____</p>