**Acupuncture and integrative medicine Associates of Nashua, PLLC**

60 Main Street #310, Nashua, NH 03060 | 603.231.2478 | www.aimaofnashua.com

**Patient Health History**

Please help us provide you with a thorough evaluation by filling out this questionnaire carefully. All of your answers will be held completely confidential. **Please mark current health issues (within the last 1-3 months) with an “X” and past health issues with an “H”.** **Please attach/include any medical reports, test results or imaging studies.** Thank you.

Date Today:\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_ Date of Appointment: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_Gender: \_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care provider name, address, phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we share this information 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, Asian medicine or Chinese herbal medicine before? Yes / No

Main reason for your visit today: \_\_\_\_Preventative care \_\_\_Wellness visit \_\_\_\_ Concern \_\_\_\_Ongoing problem (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago did your concern or problem begin? Please be specific (give a date or specific incident if possible): \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How does this impact you? What would you like to be able to do that you cannot? List one or two goals for this treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Medical History** (Circle all that apply to you): *Heart / Kidney / Liver / Lung Disease Cancer Diabetes Stroke Asthma* ↑/↓ *Blood Pressure* ↑*Cholestorol* ↑/↓ *Blood Sugar Seizures Arthritis* ↑/↓ *Thyroid Disease Anxiety Depression Osteopenia Osteoporosis* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations or surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**List prescription medications, supplements, and over the counter medications, with dosages:** (add a separate sheet if necessary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List all allergies or sensitivities:** (Drugs, Latex, Foods, Chemicals, Seasonal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Current Height**: \_\_\_\_\_\_\_\_\_\_ **Current Weight**: \_\_\_\_\_\_\_\_\_

EENT

\_\_Poor vision \_\_Blurry vision \_\_Cataracts \_\_Glaucoma \_\_Eye strain \_\_Night blindness \_\_Color blindness \_\_ Floaters/pots \_\_Eye pain \_\_Eye redness \_\_Eye dryness \_\_Eye itching \_\_Excessive tearing \_\_ Earaches \_\_Ear infections \_\_Ear pressure \_\_Dry ears \_\_Itchy ears \_\_↑ wax \_\_Tinnitus \_\_Poor hearing \_\_Sinus problems \_\_Sinus infections \_\_Sinus congestion \_\_Runny nose \_\_Post nasal drip \_\_ Nose bleeds \_\_Jaw problems \_\_Clenching teeth \_\_Grinding teeth \_\_Dental surgery \_\_Poor dental health \_\_Bleeding Gums \_\_Dry mouth \_\_Dry throat \_\_Sore throat Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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IMMUNE

\_\_Hepatitis \_\_ HIV/AIDS \_\_Herpes virus \_\_HSV \_\_HPV \_\_Measles \_\_Mumps \_\_ Rubella \_\_Diphtheria \_\_Influenza \_\_Common Cold \_\_ Tetanus \_\_Tuberculosis \_\_ Giardiasis \_\_Meningitis \_\_ CMV \_\_Cold sores \_\_Herpes Zoster/Shingles \_\_Varicella-zoster/Chickenpox \_\_Epstein-Barr/Mononucleosis \_\_Pertussis/Whooping Cough

How many times per year do you experience common cold, illness or infection of any type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When you get sick, do the symptoms quickly or easily progress to chest/lung congestion or infection? Yes / No

NEURO

\_\_Significant physical trauma (Sports injuries, motor vehicle accidents, falls, broken bones, joint dislocations, or head injuries)

\_\_Headaches \_\_Lightheadedness \_\_Dizziness \_\_Vertigo \_\_Concussion \_\_Head injury \_\_Loss of consciousness \_\_Tremors \_\_Tics \_\_Seizures \_\_Poor memory \_\_Difficulty concentrating \_\_Disordered thinking \_\_Other problems with thinking

\_\_Peculiar tastes \_\_Peculiar smells \_\_Lack of coordination \_\_Clumsiness \_\_Loss of balance \_\_Dropping items \_\_Paralysis \_\_Muscle weakness \_\_Muscle Pain \_\_Joint Pain \_\_Bone Pain \_\_ Pain gets worse with weather: \_\_\_\_Yes \_\_\_\_No

Pain gets worse with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pain gets better with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Areas of numbness \_\_Tingling \_\_Abnormal sensation \_\_Neuropathy \_\_Abnormal reflexes \_\_ Facial asymmetry \_\_Range of motion loss, stiffness, or flexibility loss (location):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANS

\_\_Fevers \_\_Body temp runs warm/hot \_\_Hands or feet hot or sweating \_\_Chills \_\_Body temp runs cool/cold \_\_Sweat easily

\_\_Hot flashes during day or night \_\_ Night sweating \_\_Spontaneous day sweating \_\_Difficulty with body temp regulation

SKIN

\_\_ Hives \_\_Rashes \_\_Dryness \_\_Psoriasis \_\_Eczema \_\_Itching \_\_Dandruff \_\_Ulcerations \_\_Pimples \_\_Acne \_\_Rosacea \_\_Edema or swelling \_\_Hair loss \_\_Recent moles \_\_ Changes in hair or skin texture:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LUNGS/HEART/THORAX

\_\_Bleed easily \_\_Bruise easily \_\_Shortness of breath \_\_Bronchitis \_\_Pneumonia \_\_Emphysema \_\_Asthma \_\_COPD

\_\_Difficulty breathing \_\_Pain with deep breath \_\_Cough with phlegm \_\_Dry cough \_\_Coughing blood \_\_Wheezing

\_\_ Subcostal tension/tightness under ribs \_\_Fainting \_\_Chest pain \_\_Chest pressure \_\_Chest tightness \_\_Heart palpitations \_\_Irregular heartbeat \_\_Cold hands or feet \_\_Blood clots \_\_ Poor circulation \_\_Swelling of hands, feet, or lower extremities \_\_Varicose veins \_\_Peripheral vascular disease Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BLOOD PRESSURE and PULSE: Typical/average readings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GI/GU:

Appetite: Normal ↑/ ↓ \_\_Thirst: Normal ↑/ ↓ \_\_Nausea \_\_Vomiting \_\_Heartburn \_\_GERD \_\_Reflux \_\_Bad breath \_\_Gassiness \_\_Bloating \_\_Belching \_\_Flatulence \_\_Indigestion \_\_Abdominal pain \_\_Abdominal cramps \_\_Diarrhea \_\_Constipation \_\_Soft stools \_\_Alternating between constipation and diarrhea \_\_Black, clay, or abnormal colored stools \_\_Thin or ribbon-like stools \_\_Blood in stools \_\_Mucous in stools \_\_Undigested food in stools \_\_Long-term laxative use

\_\_Loss of stool/bowel incontinence \_\_Rectal pain \_\_Hemorrhoids \_\_Anal fissure \_\_Urinary urgency \_\_Frequent urination \_\_\_Loss of urine/bladder incontinence \_\_Night time urination \_\_Urinary delay \_\_Decreased flow \_\_ Pain during urination \_\_ Cloudy urine \_\_Urine with foul odor \_\_Dark urine \_\_ Blood in urine Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary frequency (average times/day): \_\_\_\_\_\_\_\_ Bowel movement frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_times/day \_\_\_Can skip days

ENERGY

\_\_Fatigue \_\_Fatigue after eating \_\_Sudden decrease in the afternoon \_\_Sudden decrease during the day at: \_\_\_\_am\_\_\_\_ pm

Current energy level (0 = sleeping, 10 = highest): \_\_\_\_/10 Average energy level: \_\_\_\_/10 Normal energy level: \_\_\_\_/10

ADL/IADL: \_\_Use of assistive devices (mobility, bathing, dressing) \_\_Assistance with self-care, home, or daily living tasks

LIFESTYLE

\_\_ Food intolerances \_\_ Restricted diet? Reason/describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you skip any meals? If yes, which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cravings: sweet, salty, chocolate, crunchy, other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeinated coffee, tea, or soda per week or day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average daily life stress level: \_\_Low \_\_Low-Moderate \_\_Moderate \_\_Mod-High \_\_High Well / Poorly managed?

What are your coping strategies/how do you decompress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Experience with relaxation techniques/meditation/visualization exercises: Yes / No / Interested Was it helpful? Yes / No / NA

Alcohol or recreational drug use and amount per day, week, or month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco or nicotine use and amount per day, week, or month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth city and state:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_M \_\_D \_\_W \_\_S Number of children and/or pets living with you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FT/PT/Work from home/Out of Work/Retired/Homemaker

Hobbies or interests:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regular exercise program: Yes / No Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spirituality or religious orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SLEEP

\_\_Not feeling rested upon waking \_\_Not enough sleep \_\_Difficulty getting to sleep \_\_Night-time waking \_\_Light sleeper \_\_Waking with physical discomfort \_\_Sleep walk \_\_Sleep talk \_\_Dream disturbed sleep Total amount per night: \_\_\_\_ hours

PSYCHOSOCIAL

Tendencies: \_\_Worry \_\_Over thinking \_\_Stress \_\_Frustration \_\_Anger \_\_Fearfulness \_\_Sadness \_\_ Depression \_\_ Anxiety \_\_History of suicidality \_\_Suicidal ideation \_\_Limited support system \_\_Adequate support system \_\_ Optimist \_\_Pessimist \_\_Introvert \_\_Extrovert \_\_Have you had therapy or treatment for stress or emotional problems? Did it help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship with spouse, parents, siblings: \_\_ Good \_\_ Fair \_\_Poor Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REPRODUCTIVE

\_\_Erectile dysfunction \_\_Change in libido \_\_Testicular pain or injury \_\_Testicular cancer \_\_Prostatitis \_\_Prostate CA

\_\_Benign prostatic hypertrophy or enlarged prostate \_\_Seminal fluid leakage \_\_Low sperm count or motility \_\_STD’s \_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last menstrual period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last PAP/Gynecological exam date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at first menses:\_\_\_\_\_\_\_\_

Are you pregnant?\_\_\_\_Do you wish to become pregnant? \_\_\_\_ If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had fertility evaluation or treatment? If yes, when, and please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control use (please list type and length of use):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of births: \_\_\_\_ Number of pregnancies: \_\_\_\_ Number of premature births: \_\_\_\_ Number of miscarriages: \_\_\_\_

\_\_Perimenopausal \_\_Menopausal \_\_ Post menopausal (at age/year): \_\_\_\_\_\_\_\_\_\_\_

Length of menses (days): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time between menses (days): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Irregular periods \_\_Painful periods \_\_ Heavy periods \_\_Light periods \_\_ Clots in menstrual blood \_\_Dark color of blood

\_\_ Physical/emotional changes before/during/after menses: \_\_Headache \_\_Breast tenderness/swelling \_\_Abdominal cramps \_\_Low back pain \_\_Mood changes \_\_Other (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Breast lumps \_\_ Endometriosis \_\_Uterine fibroids \_\_Urinary tract infections \_\_Yeast infections \_\_STD’s

\_\_Abnormal vaginal discharge (amount/color/consistency/odor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Pregnancy Experience* (Edema or 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): \_\_\_\_\_\_\_\_\_\_\_

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Please attach or include any applicable:

\_\_X-Ray

\_\_MRI reports

\_\_MRA reports

\_\_Consultation reports

\_\_Operation/procedure reports

\_\_Office note with diagnosis list

\_\_Office note with medication list

\_\_Recent laboratory or blood tests

\_\_Recent office notes from other providers (Specialists, orthopedic, OT, PT, Chiropractic, etc.)

**Reserved for provider use only below this line**

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Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment Plan (Duration/Frequency):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment Provided Today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

\_\_Decrease level of discomfort to allow for optimal quality of life

Referrals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_