Dear

Thank you for choosing The Acupuncture & Herbal Center. Please fill out the health history questionnaire completely and bring it with you for your first treatment. Your appointment is _____. If you need to change this appointment for any reason, we kindly ask for 24 hours notice. I look forward to seeing you.

Sincerely,
Brian Whidden
Licensed Acupuncturist

HEALTH HISTORY QUESTIONNAIRE

Name: Kristen Pimentel	**Day Phone: 774- 487-4130**	**Evening Phone:**
Street 58 Montgomery Dr.	**Town Plymouth**	**Zip 02360**
D.O.B. 10/05/1985	**E-Mail Kristen.Pimentel@yahoo.com**	
Marital Status: Married	**Height 5'-2"**	**Weight: 165**
In case of an emergency, please notify: Telephone#:774-487-4130	**Tiago Pimentel**	
Social Security	**002-96-7856**	**Family Physician: Dr.Robke**
Insurance Company Subscriber:Tiago Pimentel	**United Health Care Policy Number:911-87726-04**	
Referred by:google		

Have you ever been treated with Acupuncture or Oriental Medicine before? If so, where and when?
yes. Dr. Raylove Barnstable, MA

Have you had any other type of alternative therapy in the last year (Chiropractic, Massage, etc.)? If so, where and when?_____Massage. Multiple places

_____

_____

Main Complaint(s) List in order of priority and include date problem began:

#1 8 days Over due pregnant.

#2_____

#3_____

#4_____

#5_____

Any other issues:_____

_____

Family Medical History: Diabetes, Cancer, High Blood Pressure, Heart Disease, Stroke, Seizures Asthma Allergies, etc. __no_____

_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)_____

__pre natal vitamins, Iron, pepcid ac, prednisone, ammoxicillin, augmentin

_____

_____

Occupation _Hairstylist _____ Occupational Stress (chemical, physical, psychological)

_____

_____

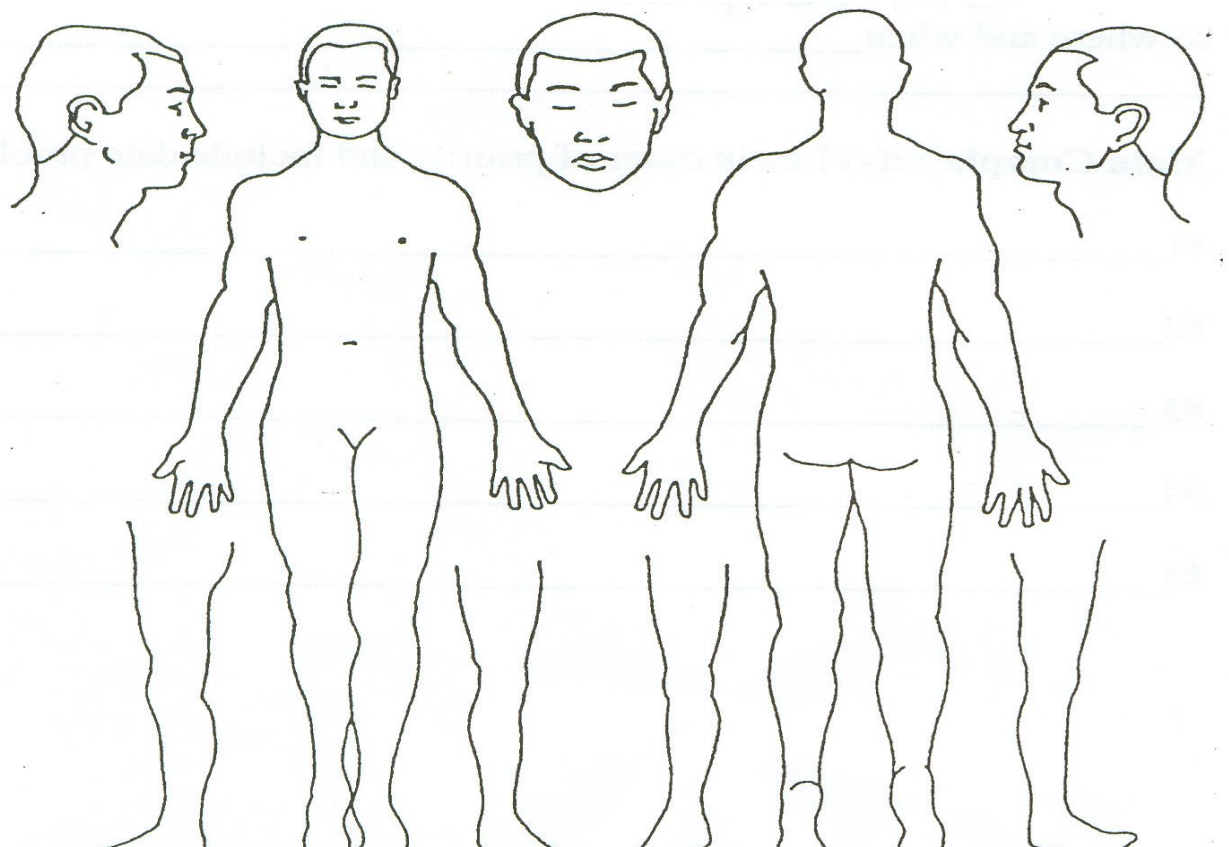
Do you have a regular exercise program? ____no_____ Please describe_____

_____

_____

Have you ever been on a restricted diet?____no_____ What kind?___ _____

Indicate painful or distressed areas:



Please check if you have had (in the last three months):

GENERAL:

ˆ Poor Appetite ˆ Poor sleeping ˆ Fatigue
ˆ Fevers ˆ Chills ˆ Night sweats
ˆ Sweat easily ˆ Tremors ˆ Cravings
ˆ Localized weakness ˆ Poor balance ˆ Change in appetite
ˆ Bleed or bruise easily ˆ Weight loss ˆ Weight gain
*(pregnant)
ˆ Peculiar tastes or smells ˆ Strong thirst (cold or hot drinks) ˆ Sudden energy drop
(What time of day?)

MUSKULOSKELETAL:

ˆ Neck pain ˆ*(work related Muscle pains ˆ
*(Shoulders,work) Knee pain
ˆ Back pain ˆ Muscle weakness ˆ Foot/ankle pain
ˆ Hand/wrist pains ˆ Shoulder pain * ˆ Hip pain*
(pregnancy)
Any other joint or bone problems?_____
_____

REPRODUCTIVE AND GYNECOLOGIC:

__3_ Number of pregnancies __2_ Number of Births ____ Premature births
_____ Number of miscarriages ____ Abortions __12 Age at first menses
_28_ Days between menses __7_ Duration
___April9, 2019_ 1st day of last menses _____last year_____ date of last PAP smear

ˆ Unusual character (heavy/light) ˆ Irregular ˆ Clots
ˆ Painful periods ˆ Vaginal sores ˆ Breast lumps
ˆ Vaginal discharge ˆ Menopause (Age _____)
ˆ Changes in body/psyche prior to menstruation
Do you practice birth control?_____ What type and for how long? _____

RESPIRATORY:

ˆ Cough **ˆ Cough blood ˆ Asthma
ˆ Bronchitis ** ˆ Pneumonia ˆ** Pain with
deep breath
ˆ Difficulty breathing when lying down ˆ Production of phlegm (what color)?_____
Any other lung problems?_____

**_Ive starred cough, brochitis and pneumonia because I recently had brochitis, still have a cough and am prone to pneumonia _____

CARDIOVASCULAR

Í High Blood Pressure Í Low Blood Pressure Í Chest pain
Í Irregular heart beat Í Dizziness Í Fainting
Í Cold hands or feet Í Swelling of hands Í Swelling of Feet
Í Blood clots
Any other heart or blood vessel problems? _____

GASTROINTESTINAL

Í Nausea Í Vomiting Í Diarrhea
Í Constipation Í Gas Í Belching
Í Black stools Í Blood in stools Í Indigestion
Í Bad breath Í Rectal Pain Í Hemorrhoids
Í Abdominal pain or cramps Í Chronic laxative use
Any other problems with your stomach or intestines? _____

GENITO-URINARY

Í Pain on urination Í Frequent urination Í Blood in urine
Í Urgency to urinate Í Unable to hold urine Í Kidney Stones
Í Decrease in flow Í Impotency Í Sores on genitals
Do you wake up to urinate? _____ How often? _____
Any particular color to your urine (if yes, please describe)? _____
Any other problems with your genital or urinary system? _____

HEAD, EYES, EARS, NOSE AND THROAT

Í Dizziness Í Concussions Í Migraines**
Í Glasses Í Eye strain Í Eye pain
Í Poor vision Í Night blindness Í Color blindness
Í Cataracts Í Blurry vision Í Earaches
Í Ringing in ears Í Poor hearing Í Spots in front of eyes
Í Sinus problems Í Nose bleeds Í Recurrent sore throat
Í Grinding teeth Í Facial pain Í Sores on lips/tongue
Í Teeth problems Í Jaw clicks
Í Headaches, ** where and when?
_____
Any other head or neck problems? _____

SKIN AND HAIR

Í Rashes Í Ulcerations Í Hives
Í Itching Í Eczema Í Pimples
Í Dandruff Í Loss of hair Í Recent moles
Í Change in hair or skin texture Any other hair or skin problems? _____

NEUROPSYCHOLOGICAL

Í Seizures Í Dizziness Í Loss of balance

ٱ Area of numbness	ٱ Lack of coordination	ٱ Poor memory
ٱ Concussion	ٱ Depression	ٱ Anxiety
ٱ Bad Temper	ٱ Easily susceptible to stress	

Have you ever been treated for emotional problems? _____

Have you ever considered to attempted suicide? _____

Any other neurological or psychological problems? _____

COMMENTS:_____

_____