The Marlborough Wellness Center
Where Modern and Traditional Medicine Become Integrated
277 Main Street, Ste. 208 • Marlborough, MA 01752

General Health History And Intake Form

Please fill this form out to the best of your ability. All information will be kept confidential.

Date: ____________________
Name (Last, First): ____________________
Address: ____________________
City, State, and Zip: ____________________
Home Phone: ____________________
Daytime Phone: ____________________
Emergency Contact Name/Phone: ____________________
Date of Birth: ____________________ Age: __________
Occupation: ____________________
Referred By: ____________________
Primary Care Physician/Contact #: ____________________
Email address: ____________________

Have you been treated by acupuncture or Oriental Medicine before? YES NO
Main concern(s) you would like us to address: ____________________

____
When did this begin? ____________________
How does it interfere with your daily activities (i.e.: work, sleep, sex)?

____
Have you been given a Formal diagnosis for this problem?

____
What other treatments have you tried? ____________________

Family Medical History (circle all applicable)

Diabetes Cancer High Blood Pressure Heart Disease Stroke
Seizures Asthma Allergies Other:

Past Medical History

Significant Illnesses (circle all applicable and specific dates)
Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever/childhood diseases Thyroid Disease Other:
Surgeries: ____________________

____
Significant Trauma (auto accidents, falls, etc.):

____

____
Allergies (drugs, metals/chemicals, foods):

____
Medicines taken in the last 3 months (vitamins, drugs, herbs):

____

____

Personal Information

Do you exercise regularly? If yes, please describe:

____

____

Have you ever been on a restricted diet? If yes, what kind and why?

____

____

Please describe your average daily diet (please be specific):

Morning: ____

Afternoon: ____

Evening: ____

Do you currently smoke? YES NO If yes, how much per day? ____________

If no, do you have a history of smoking? YES NO

If yes, how much per day and when did you quit? ____________________

Please describe any use of drugs for non-medical purposes:

____

How many caffeinated beverages do you drink per day?

____

How much water do you drink per day?

____

How much alcohol do you drink per day?

____

Are there any other concerns you would like us to address?

____

____

____

____

____

In all the areas listed below, please circle if you have experienced any symptoms in the past 3 months:

General

Fevers Sweat easily Bleed or bruise easily Change in appetite

Sudden energy drop (if yes, what time of day?) ____________________

Poor sleeping/insomnia chills Weight loss/gain Strong thirst

Fatigue Night sweats Cravings (if yes, what? ____________________

Skin and Hair

Rashes Itching Change in hair/skin texture Ulcerations Eczema Hives

Loss of hair Acne Recent moles other: ____________________

Head/Eyes/Ears/Nose/Throat

Dizziness Glasses Poor/blurry vision Cataracts Eye strain Eye pain

Eye surgeries (if yes, what? ____________________) Color Blindness

Floaters (spots in front of eyes) Night blindness Tinnitus (Ringing in ears)

Earaches Poor hearing (hearing aids?)

Headaches/Migraines (if yes, where located? ____________________)

Sinus problems Teeth grinding Concussions Nose bleeds jaw clicks

Recurrent sore throats Sores on lips/tongue Other:

____

Cardiovascular

Blood pressure: high or low   Irregular heartbeat   cold hands/feet
History of blood clots   difficulty breathing   Swelling of hands/feet
Phlebitis   chest pain   fainting   Other: ______________________________

Respiratory

Cough   bronchitis   difficulty breathing when lying down   asthma
Production of phlegm (if yes, what color? ______________________________)
Coughing blood   pneumonia   pain with deep breath   Other: ______________

Gastrointestinal

Nausea   vomiting   diarrhea   constipation   gas   belching   black stools
blood in stools   indigestion   bad breath   rectal pain   hemorrhoids
bleeding gums   abdominal pain/cramps   chronic laxative use   other: __________

Genitourinary

Pain upon urination   frequent urination   blood in urine   urgency to urinate
unable to hold urine   night urination (if yes, how frequently? ______________)
Kidney stones   decrease in flow   impotency   sores on genitals   other: _______

Reproductive

Are you pregnant? **Yes** **no**
Is it possible you could be pregnant? **Yes** **no**
Pregnancies: #_______   Live births: #_______   Miscarriages: #_______
Abortions: #_______   Premature births: #________   Date of last PAP: ______
Age of first menses: _______   Duration of menses: ________
Irregular periods   spotting between periods   unusual character (heavy, light)
Painful periods   clots   vaginal discharge   vaginal sores   breast lumps
Any changes in body/psyche prior to menses onset (PMS): ______________________
Menopause: Age ______   Practice birth control (if yes, what kind? __________)

Musculoskeletal (please circle areas where you experience pain)

Neck   back/spine   hand/wrist   shoulder   elbow   knee   ankle   hips
Muscle weakness   numbness   parasthesias (tingling)   other: ______________

Neuropsychological

Seizures   dizziness   loss of balance   lack of coordination   poor memory
Concussion   depression   anxiety   bad temper   easily susceptible to stress
Been treated for emotional challenges? **Yes** **no**
Have you ever considered or attempted suicide? **Yes** **no**
Any other neuropsychological issues? __________________________________

For practitioner use only

Observations:
____

Pulses

Comments: ______________________

Tongue

Abdominal Palpation

Comments: ______________________

Diagnosis:

____

Treatment Principle(s):

____

____

Treatment Plan:

____

____

____

Prognosis:

____