www.OrlaCallahan.com
154 East Central St, Suite 202B, Natick, MA 01760.
Text or Call: **(781) 392 6320**

Health History Form

Please help us provide you with a complete evaluation by taking the time to fill out this form. All information provided is confidential. Thank you.

Name: ____ Date: ______/______/______
(first) (last)

Date of Birth: _______/_______/_______ Age: _______ Gender: M/F Marital status: ____________

Address: Street: ____ City: _________________ State: ______ Zip: ___________

Cell Phone: ___________________________ Work Phone: _____________________

Email: ____ Please indicate the best way to reach you: ________________________

Emergency contact and/phone number: ____

Occupation: ____ Referred by: ____

Have you been treated with Acupuncture before? Y/N

MAIN REASON FOR SEEKING ACUPUNCTURE

Main reason you are seeking acupuncture ____

____

____

____

Does this situation interfere with your daily activities? ____

Have you been given a Diagnosis? ____

What other modalities have you tried? ____

Other Issues you would like to work on: ____

____

____

How would you you're your health to be different in 3 months from now? 1 year from now?

____

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____

____

____

GENERAL

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking: ____________________

____

Allergies: ____

Surgeries/Major Injuries: ____

How much caffeine per day? ______________________ How much water? _____________________ Alcohol? ___________________

Do you typically eat 3 meals per day? Y/N. If no, how many?______________________________________

Exercise routine: ____

MEDICAL HISTORY

Personal Medical History – Past or Present

☐Cancer	☐Diabetes	☐Hepatitis
☐Stroke	☐Heart Disease	☐High Blood Pressure

General

☐Anemia	☐Rashes	☐Eczema/Hives	☐Cold Hands/Feet
☐Poor Sleep	☐Weight loss/gain	☐Bruise Easily	☐Thirst
☐Fatigue	☐Slow Wound Healing	☐Chronic Infections	☐Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat

☐ Impaired Vision	☐ Headaches	☐ Earaches	☐ Dry Throat
☐ Tearing/Dryness of eyes	☐ Sinus Problems	☐ Ear ringing	☐ TMJ/Jaw Problems
☐ Eye Pain/Strain	☐ Hay Fever	☐ Impaired Hearing	☐ Teeth Grinding
☐ Floaters	☐ Nose Bleeds	☐ Frequent Sore Throats	☐ Other

Respiratory

☐ Cough/Wheezing	☐ Asthma	☐ Shortness of Breath
☐ Difficulty breathing	☐ Frequent Common Colds	☐ Pain with a deep Breath
☐ Pneumonia	☐ Emphysema	☐ Production of Phlegm, if so what color?
☐ Bronchitis	☐ Lung Disease	☐ Other Respiratory Problems: __________

Cardiovascular

☐ Heart Disease	☐ High Blood Pressure	☐ Swelling of Ankles
☐ Chest Pain	☐ Low Blood Pressure	☐ Irregular Heart Beat
☐ Palpitations	☐ Fainting	☐ Varicose Veins / Clot

Gastrointestinal

☐ Nausea	☐ Abdominal Pain	☐ IBS/Crohn's Disease
☐ Vomiting	☐ Belching	☐ Hemorrhoids
☐ Diarrhea	☐ Gas	☐ Bad Breath
☐ Constipation	☐ Indigestion/Acid Reflux	☐ Rectal Pain
☐ Bloating	☐ Chronic Laxative use	☐ Spleen/Stomach Disease
☐ Gall Bladder Disease	☐ Liver Disease	☐ Other_______________

Genito-Urinary

☐ Kidney Disease	☐ Painful Urination	☐ Frequent UTI
☐ Urination at Night	☐ Blood in Urine	☐ Urgent Urination
☐ Frequent Urination	☐ Kidney Stones	☐ Prostatitis
☐ Decreased Libido	☐ Impotence	☐ Other_________________

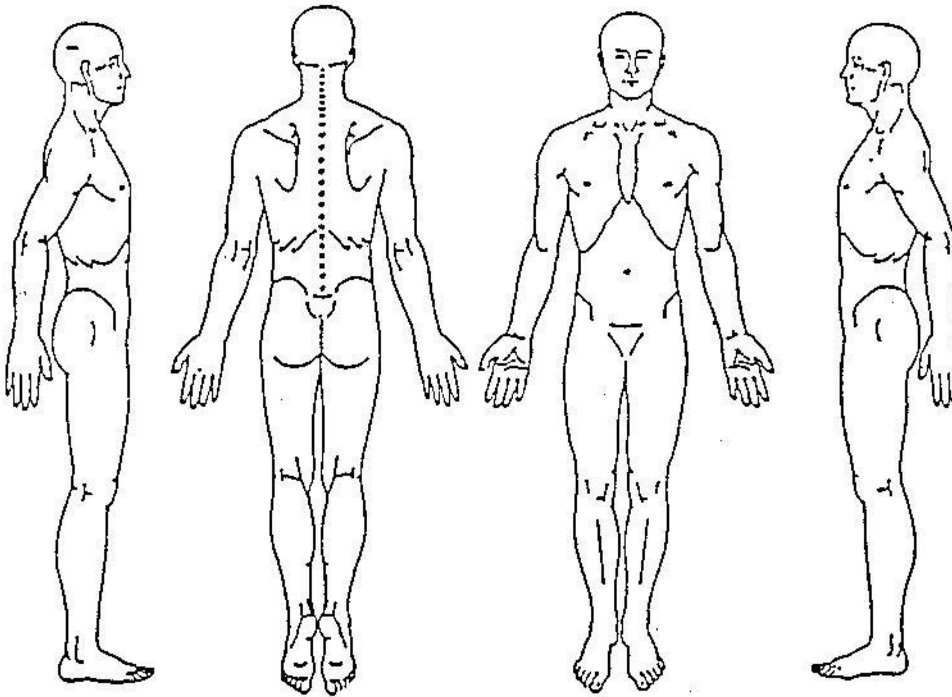
Women's Health

☐ Painful Periods	☐ Fibroids	Date of last Menses_____
☐ Irregular Cycles	☐ Polycystic Ovarian Disease	Date of last PAP________
☐ Vaginal Discharge	☐ Premenstrual Problems	Age of first Menses______
☐ Menopausal Symptoms	☐ Ovarian Cysts	
☐ Endometriosis	☐ Infertility	Other____________________

Musculoskeletal

- ☐Back Pain
- ☐Arm Pain
- ☐Sciatica
- ☐Shoulder Pain
- ☐Leg Pain
- ☐Carpal Tunnel Syndrome
- ☐Neck Pain
- ☐Joint Pain
- ☐Muscle Spasms/Cramps
- ☐Knee Pain
- ☐Hand Pain
- ☐Bursitis
- ☐Tendonitis
- ☐Foot Pain
- ☐Other_________________

Please indicate any painful or distressed areas by circling the area.



Neurologic

- ☐Vertigo/Dizziness
- ☐Seizures/Epilepsy
- ☐Numbness/Tingling
- ☐Loss of Balance
- ☐Paralysis
- ☐Poor Memory
- ☐Areas of Numbness
- ☐ADD/ADHD
- ☐Other______________________

Endocrine

☐Hypothyroid ☐Hyperthyroid ☐Night Sweats

☐Hypoglycemia ☐Feeling Hot or Cold ☐Other______________________

Emotional/Psychological

☐Anxiety/Panic Attacks ☐Depression ☐Bad Temper/Irritable

☐Mood Swings ☐Nervousness ☐Easily Susceptible to Stress

Do I have your permission to send you my newsletter via email?

(Correspondence is usually once a month).

☐Yes ☐No