



# ASSABET VALLEY NATURAL HEALTH

Acupuncture . Nutrition . Bodywork . Peri-Natal Care

Please take the time to fill out this questionnaire carefully They are important in us working together to achieve your health goals. All of your answers are held absolutely confidential.

Today's Date:				
Name (First & Last)		Home Phone ( ) -		Work/Cell Phone ( ) -
Street		City		State/Zip
Email		Date of Birth	Age	Height Weight
Occupation		Family Physician		How Did You Hear About Us?
Emergency Contact (Name & Relation to you)			Emergency Phone( ) -	
What is the main problem(s) you'd like to address? 1. 2. 3. 4.				
How long ago did this problem begin?				
To what extent does this problem interfere with your daily activities such as work, sleep, sex?				
Have you been given a diagnosis for this problem? If so, what?				
What other kinds of treatments have you tried?				

**Medical History:**

Check all conditions you've had in the past or currently have:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> CVA (stroke)          | <input type="checkbox"/> Vein condition      | <input type="checkbox"/> Thyroid disorder   |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Emphysema          |
| <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Gonorrhea             | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Bleeding tendency  |
| <input type="checkbox"/> Syphilis             | <input type="checkbox"/> Measles               | <input type="checkbox"/> Chicken pox         | <input type="checkbox"/> Nervous disorder   |
| <input type="checkbox"/> Meningitis           | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Polio               | <input type="checkbox"/> Mononucleosis      |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> High fever            | <input type="checkbox"/> Hepatitis _____     | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Eczema/Psoriasis     | <input type="checkbox"/> Migraines             | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Paralysis          |
| <input type="checkbox"/> other lung illnesses | <input type="checkbox"/> other liver illnesses | <input type="checkbox"/> Gallstones          | <input type="checkbox"/> Kidney Stones      |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> other: _____          |  |   |

Have you ever been on long term antibiotic therapy (more than 2 weeks?)

Surgeries (type and date)

Significant Trauma (auto accidents, falls, abuse etc)

Significant Dental Work (type and date)

Allergies (pollen, dander, drugs, synthetic chemicals, foods)

Family Medical History (check and include relation to you)

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer(type)  | <input type="checkbox"/> Other               |

### Present Medical History

Prescription, OTC or vitamin/mineral/supplements/herbs taken within past 3 months:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Antacids                     | <input type="checkbox"/> Antibiotics             | <input type="checkbox"/> Anticonvulsants           | <input type="checkbox"/> Antidepressants          |
| <input type="checkbox"/> Antianxiety meds             | <input type="checkbox"/> Aspirin/Ibuprofen       | <input type="checkbox"/> Asthma inhalers           | <input type="checkbox"/> Beta blockers            |
| <input type="checkbox"/> Birth control pills/implants | <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Cholesterol lowering meds | <input type="checkbox"/> Cortisone/steroids       |
| <input type="checkbox"/> Diabetic medications/insulin | <input type="checkbox"/> Diuretics               | <input type="checkbox"/> Hormone replacement       | <input type="checkbox"/> Heart Meds               |
| <input type="checkbox"/> High blood pressure meds     | <input type="checkbox"/> Laxatives               | <input type="checkbox"/> Recreational drugs        | <input type="checkbox"/> Relaxants/Sleeping pills |
| <input type="checkbox"/> Thyroid meds                 | <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Ulcer meds                |   |

**Do you know your Blood Type: (if so what is it?):**

Medication and Supplements	Dosage	Reason for Taking

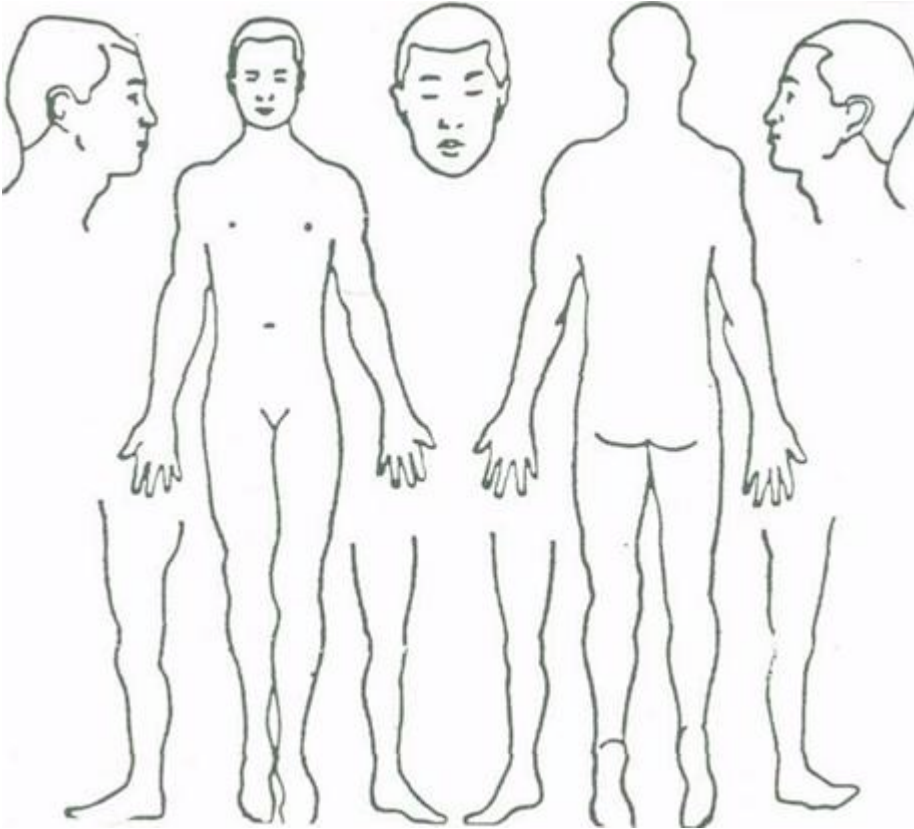
Do you have a regular exercise program?  Yes (please describe)  No

How many colds do you get per year? \_\_\_\_\_  
Describe:

Do you feel like you are under much stress?  Yes (please describe)  No

**Sleep:** Hours/Night \_\_\_\_\_ What time do you retire to bed? \_\_\_\_\_ What time do you wake? \_\_\_\_\_  
Do you feel rested when you wake up?  Yes  No  
Do you sleep through the night?  Yes  No \_\_\_\_\_  
Please add any other comments about your sleep or sleep history:

Indicate Painful or Distressed Areas



Please add any additional comments about musculoskeletal issues:

**Women only GYN**

Regular menstrual cycle?  No  Yes  
 Number of children: \_\_\_\_\_  
 Age of first menstruation: \_\_\_\_\_  
 Average number of days of flow: \_\_\_\_\_  
 Vaginal discharge  
 color \_\_\_\_\_

Pregnant?  No  Yes  
 Number of pregnancies: \_\_\_\_\_  
 Age of menopause (if applicable): \_\_\_\_\_  
 Average number of days of entire cycle: \_\_\_\_\_  
 Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> nausea        | <input type="checkbox"/> vomiting     | <input type="checkbox"/> water retention | <input type="checkbox"/> breast swelling   |
| <input type="checkbox"/> food cravings | <input type="checkbox"/> headaches    | <input type="checkbox"/> migraines       | <input type="checkbox"/> breast tenderness |
| <input type="checkbox"/> depression    | <input type="checkbox"/> irritability | <input type="checkbox"/> anxiety         | <input type="checkbox"/> other             |
- emotions: \_\_\_\_\_  
 dull pain, where? \_\_\_\_\_  sharp pain, where? \_\_\_\_\_

Please fill in the following menstrual chart. If you are menopausal please fill in best to your recollection.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Headaches/Migraines (check if yes)							
Other							

**Men only**

- |  |   |                                    |  |
|--|---|------------------------------------|--|
| <input type="checkbox"/> Swollen testes  | <input type="checkbox"/> Testicular pain  | <input type="checkbox"/> Impotence | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Feeling of coldness or numbness in external genitalia | <input type="checkbox"/> Swollen Prostate |                                    |  |
| <input type="checkbox"/> Other _____   |   |                                    |  |

**Dietary Information History and Lifestyle:**

Have you ever been on a restricted diet?  Yes (when, how long, type?)  No

What foods do you crave?

Do you get fatigued after eating certain foods?  Yes (which ones?)  No

Do you enjoy cooking?  Yes  No

Where do you do most of your grocery shopping?

What kinds of oils do you use in your food?

Please check  one column for each row based on frequency:

Less than 1X Per Month	1-2X Per Month	1X Per Week	2-5X Per Week	1X or more Per Day	
					Alcoholic beverages
					Eat at restaurants
					Eat at "Fast Food" establishments
					Pastries, cookies, candies, ice cream, other sweets
					Add sugar to food/beverages
					Colas or other soft drinks
					Caffeine drinks/food
					Deep fried foods
					Margarine, hydrogenated oils, soy oil, corn oil
					Whole grains (rice, millet, oats)
					Red meat
					Poultry
					Fresh fish
					Processed cold cuts
					Fresh fruit
					Fresh vegetables
					Salads
					Sourdough breads
					White bread or flour products
					Beans/legumes
					Yogurt (brand? _____ )
					Milk
					Cheese
					Eggs
					Salt
					Herbs, fresh or dried
					Drink adequate water
					Eat if bored or depressed
					Eat in a hurry or rushed
					Chew food well
					Overeat – feel overfull after meals
					Distractions (TV, paper) while eating
					Sneak foods
					Artificial sweeteners
					Crave Sugar

**24-Hour Cancellation/Rebooking Policy**  
**OFFICE COPY**

Your appointment time is reserved specifically for you.

If you are, for any reason, unable to keep your appointment, you must notify us at least **24 hours prior** to your scheduled appointment time to **avoid any charges**. **Partial or full payment is expected for any appointments cancelled/rebooked within 24 hours of your scheduled appointment** as outlined below:

- Acupuncture/Shiatsu cancellation/rebooks less than 4 hours before appointment will be charged 100% of fee.
- Acupuncture/Shiatsu cancellation/rebooks greater than 8 hours but less than 24 hours before appointment = 50% of fee (i.e. \$37.50 for a \$75 appointment booking)
- Nutrition cancellation/rebooks less than 24 hours = Full fee of booked time. (\$30 per 15 minutes)
- All no-shows will be charged full fee.

Of course valid emergencies and bad weather will occur and if they do you will not be charged. We want to be reasonable and this isn't about taking your money, but rather your commitment to your health. If you have concerns about the policy or making certain appointments please discuss it with us before booking your appointment.

Thank you for your understanding and respect.

**Please read and sign the statement below indicating that you fully agree to this cancellation/rebooking policy.**

**"I \_\_\_\_\_ agree to the above guidelines and agree to accept financial responsibility for any late appointment cancellations or rebookings.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**24-Hour Cancellation/Rebooking Policy**  
**PATIENT'S COPY**

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