INTEGRATIVE WELLNESS
Center for Healthcare and Education

132 Great Rd
Stow, MA 01775
978-461-2001

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	Who can we thank for the referral?		
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?

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Medical History:

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

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

☐ Asthma	☐ Heart Disease	☐ High Blood Pressure
☐ Stroke	☐ Seizures	☐ Thyroid
☐ Diabetes	☐ Cancer(type)	☐ Other

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Present Medical History

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

☐Antacids ☐Antibiotics ☐Anticonvulsants ☐Antidepressents
☐Antianxiety meds ☐Aspirin/Ibuprofen ☐Asthma inhalers ☐Beta blockers
☐Birth control pills/implants ☐Chemotherapy ☐Cholesterol lowering meds ☐Cortisone/steroids
☐Diabetic medications/insulin ☐Diuretics ☐Hormone replacement ☐Heart Meds
☐High blood pressure meds ☐Laxatives ☐Recreational drugs ☐Relaxants/Sleeping pills
☐Thyroid meds ☐Acetaminophen (Tylenol) ☐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:

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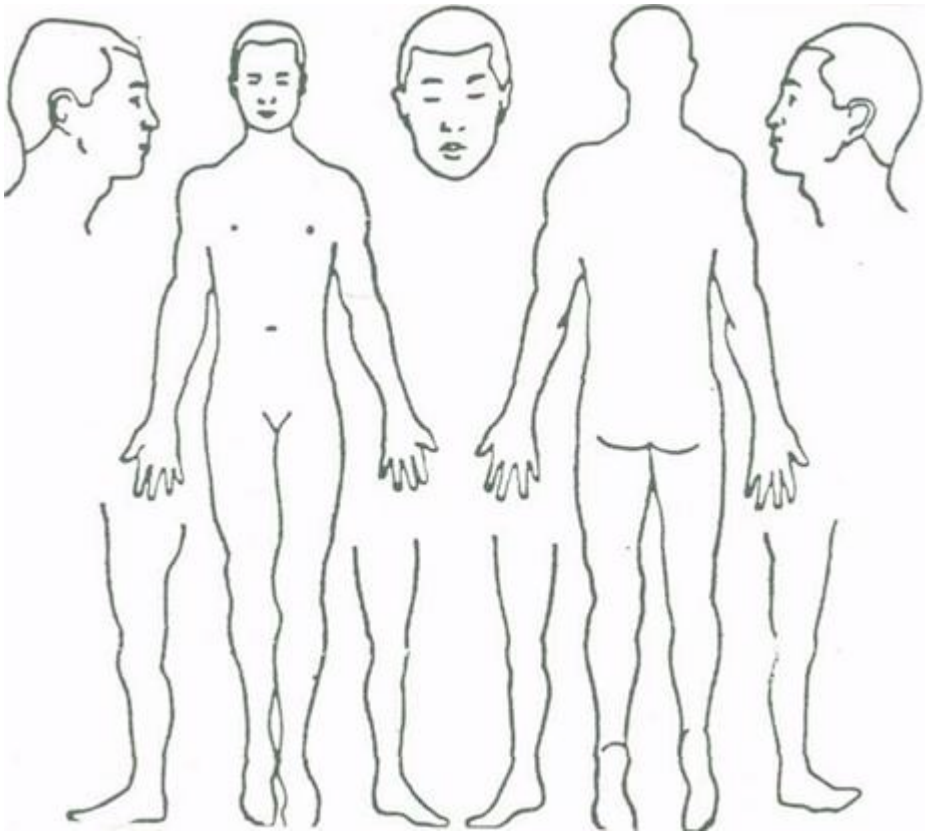
Indicate Painful or Distressed Areas



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?

☐nausea ☐vomiting ☐water retention ☐breast swelling
☐food cravings ☐headaches ☐migraines ☐breast tenderness
☐depression ☐irritability ☐anxiety ☐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_____

☐Swollen testes ☐Testicular pain ☐Impotence ☐Premature ejaculation
☐Feeling of coldness or numbness in external genitalia ☐Swollen Prostate
☐Other_____

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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

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Consent To Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, shiatsu, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, Reiki and nutritional counseling.

I understand that acupuncture, shiatsu, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks of acupuncture include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha.

I will notify my practitioner should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist/dietitian are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my practitioner may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at Integrative Wellness.

_____

Patient Signature Date

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Cancellation/Rebooking Policy

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 or 48 hours prior** to your scheduled appointment time to **avoid any charges**. **Partial or full payment is expected for any appointments cancelled/rebooked outside of the guidelines below:**

- Acupuncture cancellation/rebooks less than 24 hours will be charged a $40 fee.
- Shiatsu and Nutrition cancellation/rebooks with less than 48 hour notice are charged full fee.
- No Shows are 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 and our scheduling manageable. Your appointment time is reserved for you and cancellations are disruptive. 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.

In signing this form I agree to the above guidelines and agree to accept financial responsibility for any late appointment cancellations or rebookings.

Patient's Signature _____ Date _____

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