

42 Pleasant St. (Rt. 60)
Arlington, MA 02476
(781) 248-0565

155 Main Dunstable Rd., Suite 135
Nashua, NH 03060
(603) 566-1842

William Kellar, M.Ac.
Licensed Acupuncturist
HealingWithAcupuncture.com
info@HealingwithAcupuncture.com

Patient Information Form

Please fill out this health questionnaire and add any relevant details. All responses are kept confidential. No information is ever released without your written consent.

Date: _____

Name: _____ Age: _____ DOB: _____

Street _____

City: _____ State: _____ Zip _____ E-Mail: _____

Home phone: _____ Cell: _____ Work: _____

Primary Physician: _____ Phone: _____

In Emergency Notify: _____ Phone: _____

Are you a member of Blue Cross or Harvard Pilgrim? _____ Other: _____

Main Problem you are seeking treatment for: _____

Have you been given a medical diagnosis for this problem? If yes, please list with date(s) _____

History of Problem: (length of time, severity, level if interference with activities) _____

Secondary or Other problems: _____

General Symptoms: Please circle all that apply.

- | | | | |
|---------------------|---------------|-------------------|-----------------------------------|
| Fevers | Chills | Poor sleep | Night sweating |
| Weight loss | Weight gain | Poor appetite | Low immunity/get sick frequently |
| Food cravings | Bruise easily | Bleed easily | Sudden energy drops after meals |
| Irregular heartbeat | Fatigue | Allergic symptoms | Shortness of breath with exertion |

Current Medications: Please list name, dosage and condition: _____

Personal Medical History (including significant illnesses, surgeries, and/or injuries.) _____

Family Medical History: _____

Exercise (type and # days per week) _____

Caffeine use (# daily cups) _____

Smoking (# packs) _____

Alcohol use: (# drinks/week) _____

Recreational Drugs (Y/N) _____

Please describe an average daily diet, including snacks:

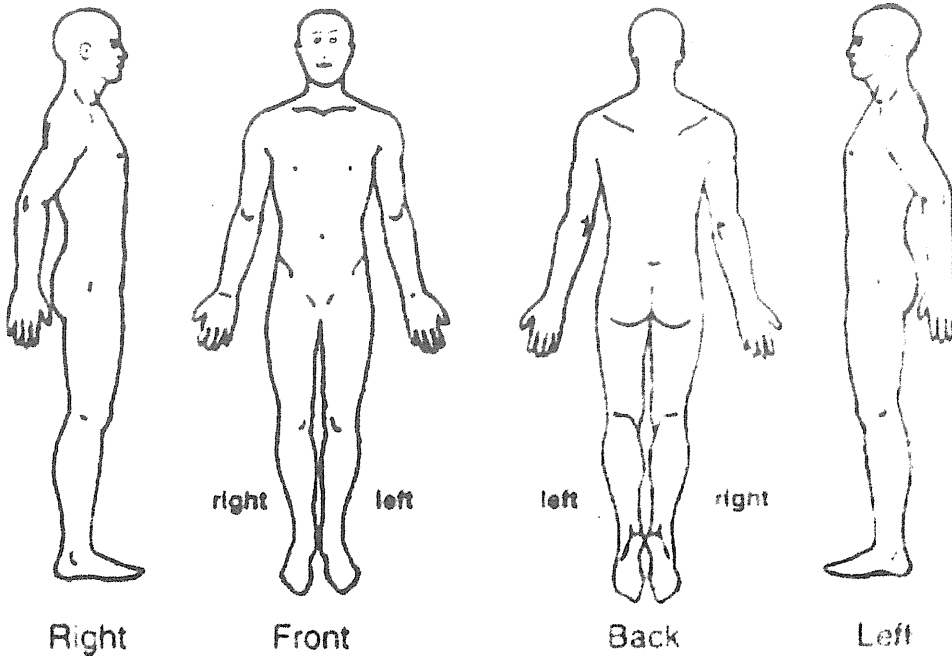
Morning

Afternoon

Evening

How much water do you drink each day? _____

Musculoskeletal: Please circle any painful or distressed area:



What, if any, are the major sources of stress in your life? _____

Please rate your current (overall) stress level with 10 being the highest.

1 2 3 4 5 6 7 8 9 10

How do you manage your stress on a regular basis? _____

Comments: Please describe anything else that you wish to discuss. _____
