HEALTH HISTORY QUESTIONNAIRE
Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. General Patient Information

Date: ____/____/____

Name: Mr./Mrs./Ms.____

Address: ____

City, State, Zip Code: ____

Home Phone: _(______)________________________

Cell Phone: _(______)________________________ Email Address: ____________________________________

Age: ______ Date of Birth: ____/____/____ Place of Birth: ____

Guardian (if under 18): ____

Emergency Contact (name and phone #): ____

Gender: θM θF Height: ____’____” Weight: ______lbs.

Occupation:______________________________Employer:__________________________________

How did you hear about our office? ____

Major Complaint(s), in order of significance to you:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________

Additional:______________________________

How do these conditions impair your daily activities?__________________________________

ANY FOOD OR METAL ALLERGIES ____

II. Patient Medical History

How was your childhood health?____

Hospital Visits/Stays:____

____

Any Medications currently taking: ____

Recent tests: (please indicate test results and date below)

θPhysical θCholesterol θProstate θBlood (which?)

θHIV/STD θPap smear θMammography θOther:____________________

Test Results and Date:____

Check any you have had in the past:

θDiabetes θAllergies θGlaucoma θRheumatic Fever

θHeart Disease θCVA (stroke) θVein condition θThyroid disorder

θAsthma θPneumonia θTuberculosis θEmphysema

θJaundice θGonorrhea θMumps θBleeding tendency

θSyphilis θMeasles θChicken pox θNervous disorder

θMeningitis θHIV θPolio θMononucleosis

θEpilepsy θHigh fever θHepatitis θMultiple Sclerosis

θParalysis θCancer θMigraines θHigh blood pressure

θother lung illnesses θother liver illnesses θother heart illnesses θother kidney illnesses

θother:_________________________________

Surgeries:____

Any other significant medical issues?