

## Health History Questionnaire

Date \_\_\_\_\_

Full Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

\_\_\_\_\_ Date of birth \_\_\_\_\_

\_\_\_\_\_ Insurance Plan \_\_\_\_\_

Home phone \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone number \_\_\_\_\_

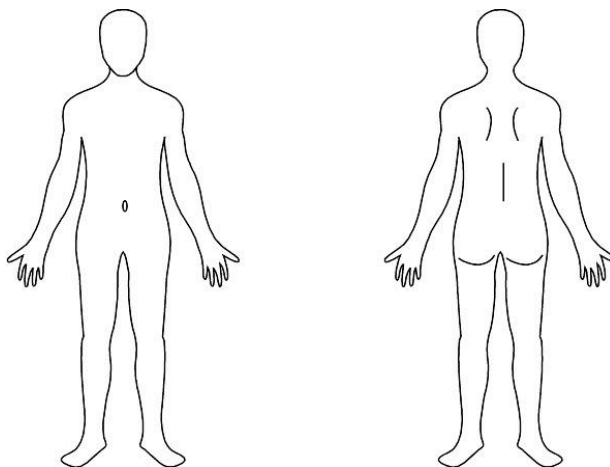
Who should we thank for referring you? \_\_\_\_\_

Have you had acupuncture before? \_\_\_\_\_ If so, where and when? \_\_\_\_\_

Please list the concerns that brought you here today:

Symptom	Date first noticed
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please indicate where your symptoms are occurring:



What other treatments have you explored? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

\_\_\_\_\_

What dietary supplements do you take regularly? \_\_\_\_\_

\_\_\_\_\_

Please describe your typical diet:

breakfast \_\_\_\_\_

lunch \_\_\_\_\_

dinner \_\_\_\_\_

snacks \_\_\_\_\_

How many cups of coffee, tea or other caffeinated beverage do you drink weekly? \_\_\_\_\_

How many alcoholic beverages do you drink weekly? \_\_\_\_\_

Are you a smoker? \_\_\_\_ If so, how many times per day do you use tobacco? \_\_\_\_\_

Do you exercise? \_\_\_\_ If so, please describe what you do: \_\_\_\_\_

\_\_\_\_\_

Please describe any that apply:

	Your own history:	Your family's history:
Heart disease		
Cancer		
Hypertension		
Thyroid disorder		
Hepatitis		
Tuberculosis		
HIV/AIDS		
STDs		
Congenital disorders		
Seizures		
Stroke		
Neurological disorders		
Other (please specify)		

Please describe any trauma or surgery you have had: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_