Health History Questionnaire

Information for your Acupuncturist

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

I. General Patient Information Date: ____/____/____

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: (____) _____

Work Phone: (____) _____ Cell :(____) _____

Email: _____

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

Marital Status: _____ Height: ___' ____" Weight: ____ lbs

Partner/Spouse: _____ Years married: _____

Children: _____

_____

Pets: _____

Occupation: _____ Employer: _____

II. Medical History

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

	Severe	Moderate	Slight	
1.	☐	☐	☐	_____
2.	☐	☐	☐	_____
3.	☐	☐	☐	_____
4.	☐	☐	☐	_____
5.	☐	☐	☐	_____
6.	☐	☐	☐	_____
7.	☐	☐	☐	_____
8.	☐	☐	☐	_____

How do these conditions impair your daily activities? _____

_____

What treatments have you tried for these conditions? _____

_____

What result have you seen? _____