

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do these conditions impair your daily activities? _____

What treatments have you tried for these conditions? _____

What result have you seen? _____
