Revised 06/13

Personal Information and Health History Form

This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you. Please fill it out as accurately as possible.

Name ________________________________ Date ______________

Name of Parent or Guardian (if under age 18)________________________

Street Address ____

City ______________________ State ______ Zip ______________

Home Phone ______________ Cell or Work Phone ______________

Email address ____

Emergency contact –

Name ________________________________ Relationship __________

Address ____

____

Home phone ______________ Work phone ______________

Birthdate ____________ Age ______

Sex: male female Height __________ Weight __________

Occupation ____

Which activities do you perform at work? ________________________

How did you hear about us? ________________________________

Have you received acupuncture before? Yes No

When? ______________ With whom? ______________________

List anything you are allergic to:

1. ______________________________
2. ______________________________
3. ______________________________

List any foods you do not eat:

1. ______________________________
2. ______________________________
3. ______________________________

Please list any medications that you take (or attach a list):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Please list any vitamins or supplements that you take:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

List any surgeries or hospitalizations your have had:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

List any injuries you have had:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

List any medical conditions that you have been diagnosed with?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

For women:

Are you, or could you be pregnant?______________

If so, When is your due date?______________________

Are you or have you been on pharmaceutical birth control? Yes No

Age of first menses__________ Age of menopause, if applicable______________

Which health concern would you like us to address today?

____

Are you under the care of a physician for this?______________

Which treatments have you tried? ______________

When did this problem begin?______________

Describe the quality/symptoms of this problem?______________

____

____

What else would you like us to address?

____

Are you under the care of a physician for this? ____________________

Which treatments have you tried? ____________________

When did this problem begin? ____________________

Describe the quality/symptoms of this problem? ____________________

____

____

Additional information:

____

____

____

____

I have provided correct and complete information to the best of my knowledge.

______________________________ ____________

Patient's or Guardian's signature Date

____

Name Printed

Please include copies of any lab work you have.