Health History Questionnaire

Todays date:

Name_____

Phone_____ email_____

Street Address: _____

City/Town_____ State_____Zip_____

Date of Birth_____ Age_____ Marital Status_____

Height_____ Weight_____

Occupation_____

In Emergency Notify:

Name and Number_____

Referred by _____

Have you been treated by Acupuncture or Oriental Medicine before? _____

Main problem(s) you would like help with:

How long has this been bothering you?

Have you been given a diagnosis for this problem?

Please list the physician/providers (and their modality) under whose care you are:

Please list all medications/herbs/supplements you are taking:

Past Medical History:
please indicate date of onset and treatment protocols

Asthma or other respiratory condition Cancer Diabetes
GERD/Crohns/Celiac or other digestive disorder Hepatitis or Liver disease
High Blood Pressure Heart Disease Lyme or other tick borne illness
Neurological Disease (Parkinson's, ALS, Alzheimer's) Reproductive disorders
Thyroid Disease Seizure disorder Venereal Disease
Other medical conditions/diseases

Surgeries (with dates):

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Significant Trauma (auto accidents, falls, assault):

Allergies:

Women: Are you pregnant?_____ LMP_____

Are you a parent? Yes/No

Please describe your exercise program:

Please describe your diet.Do you follow any dietary restrictions?

How many hours a night do you sleep?_____.
Do you have trouble falling asleep? Yes/No
Do you experience nightwaking? disturbing dreams?

Do you use tobacco? How much/how often?

Do you use alcohol? How much? How often?

Do you use caffeine How much? How often?

Sensory Acuity:
Please let me know if you experience any trouble with:

Vision:
Hearing:
Smelling:
Taste:
Touch:

Do you have a spiritual or religious practice?

What do you like to do for fun?

Any thing else you would like me to know:

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