Health History Questionnaire

PATIENT INFORMATION (please print legibly)

Name____

Age______ Today's Date ____________

Legal name (if different)_________________________________ Date of Birth_______________________

Gender___________Preferred Pronoun____________

Address____

Email ____ Phone______________________________

Occupation _____________________ How did you hear about us? _______________________________

Another person we may contact in case of emergency: Would you like to be on our email list? Y / N

Name _______________________________ Relationship___________________ Phone______________

HEALTH HISTORY

What are your primary reasons for seeking acupuncture care? How long have these issues been of concern?

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List serious illnesses, accidents or surgeries and approximate dates

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List any medications, herbs and supplements you are presently taking

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Any addictions you would like support with? ____

Do you have a pacemaker?___________________ Do you have a bleeding disorder? _________________

Check/Mark conditions you have had in the past with a P **Check/Mark conditions you have currently with a C**

☐ AIDS/HIV	☐ Allergies	☐ Asthma	☐ Cancer
☐ Depression	☐ Digestive Issues	☐ Diabetes (type:_____)	☐ Epilepsy
☐ Heart disease	☐ Hepatitis (type:_____)	☐ High blood pressure	☐ Insomnia
☐ Low blood pressure	☐ Pregnant or Trying	☐ Stroke	☐ Tuberculosis