

Health History Questionnaire

Name		Sex	Age	
Address		City	State	Zip Code
Home Phone	Work Phone	Cell	Email	
Date of Birth	Height	Weight	Occupation	
How did you hear about our clinic?		Have you ever been treated by acupuncture before?		
MAIN HEALTH ISSUES:				
<p>Please write in your top 3 health issues/concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=can't imagine it being worse)</p>		<p>2. _____ When did this start? _____ ago Heat makes it: better no change worse Cold makes it: better no change worse Damp weather: better no change worse 1 _____ I _____ 10</p>		
<p>1. _____ When did this start? _____ ago Heat makes it: better no change worse Cold makes it: better no change worse Damp weather: better no change worse 1 _____ I _____ 10</p>		<p>3. _____ When did this start? _____ ago Heat makes it: better no change worse Cold makes it: better no change worse Damp weather: better no change worse 1 _____ I _____ 10</p>		
HEALTH HISTORY				
<p>Circle the “you” if you have / had the condition and note the year it started. Circle the “family” if there is a family history of the condition.</p>				
Cancer you/family year: _____ type: _____	Diabetes you/family year: _____	Hepatitis you/family year: _____ type: _____	High Blood Pressure you/family year: _____	
Heart Disease you/family year: _____	Stroke you/family year: _____	Seizure Disorder you/family year: _____	Thyroid Disease you/family year: _____	
Asthma you/family year: _____	Pacemaker you/family year: _____	Osteoporosis you/family year: _____	Herpes you/family year: _____	
AIDS/HIV you/family year: _____	Other STD you/family year: _____	Rheumatic Fever you/family year: _____	Alcoholism you/family year: _____	
Allergies you/family year: _____ type: _____	Mental Illness you/family year: _____	Kidney Disease you/family year: _____	Anemia you/family year: _____	
Habits Amount/Week If quit/year	Exercise Do you exercise regularly Yes/No If so, what and how often	Diet Do you have a special diet now or in the past? Describe with dates:	Medication Please note what medications, herbs or supplements that you take regularly	Injuries/Surgeries Please note what happened to what body area and when it occurred.
Coffee/tea _____				
Soda _____				
Tobacco _____				
Alcohol _____				
Drugs _____				

