

Health History Questionnaire

Please help me to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held confidential, unless you sign an authorization form for your records to be released.

Name (Last, First)	Date of Birth: Sex:	Today's Date:
Address:	City: State:	Zip:
Primary Phone:	Name of Emergency Contact:	Emergency Contact Phone:
Primary Physician:	Date of last physical:	Referred by:
Email:	How do you prefer to be contacted? Phone <input type="checkbox"/> Email <input type="checkbox"/>	Is it okay to send you my quarterly newsletter by mail?

Have you ever been treated by acupuncture before? Yes No

What health concern(s) do you want to address?
How long ago did this/these health concern(s) begin?
Is there a known cause/instigating factor for your health concern?
Have you seen a doctor about this/these concern(s)? If so, has your doctor given you a diagnosis?
What treatments have you tried?
Is there a chance that you may be pregnant? (Females)
List medications you are currently taking, including herbs and supplements:
List any significant traumas and approximate date(s) (auto accidents, injuries, emotional traumas, etc.):
List any surgeries you have had (indicate date):
Do you have a regular exercise program? (Describe)
Are you on a restricted diet? (If so, what type)