CONFIDENTIAL HEALTH HISTORY

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential. If you have any questions, please feel free to ask.

Today's Date _____

Name _____ Date/Place of Birth _____

Address_____ City _____ State _____ Zip _____

Tel: Work _____ Home _____ Cell _____

E-mail _____ Age _____ Height _____ Weight _____ Sex _____

Occupation_____ Referred by _____

Name & Tel# of Physician _____

Emergency Contact Name & Tel# _____ Relationship _____

Below, please briefly describe what would you like treated with acupuncture, when this condition(s) developed, how it has affected you, any medical diagnoses, and what kind of therapies you have already tried.

_____

_____

_____

_____

_____

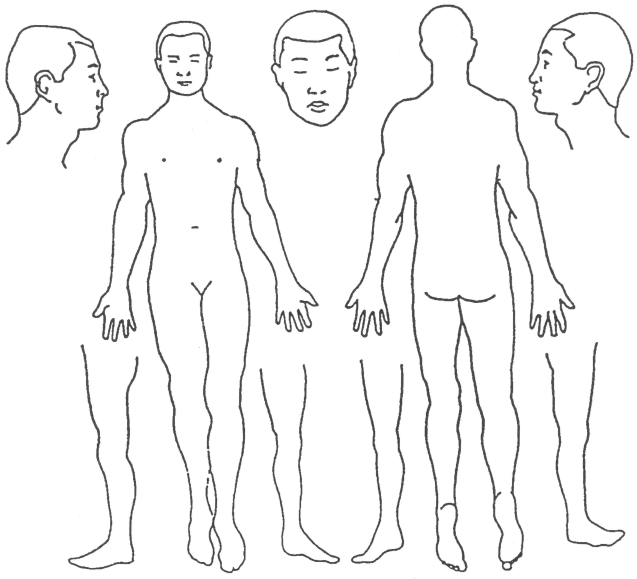
_____

_____

_____

Are you currently pregnant? _____ Are you presently trying to become pregnant? _____

Please shade any areas of pain or distress on the diagram below:



Rate your degree of physical distress (0=none, 10=worst possible): 0 1 2 3 4 5 6 7 8 9 10
Rate your degree of emotional distress (0=none, 10=worst possible): 0 1 2 3 4 5 6 7 8 9 10

Medical History Please list any trauma, broken bones, head injuries, scarring wounds, onset of health changes, recurring, chronic or major illnesses, other relevant life events, and ALL surgeries (attach pages if needed):
Age Incident

Family Illnesses recurring in immediate family_____

Medications List the type currently taking, what it is for, and how long you've been taking it; include supplements.

Antibiotics: _____ times in the past 10 years _____frequent childhood use
Vaccine reactions: _____

Women Deliveries:_____ Miscarriages:_____ Abortions:_____
Birth control pills: current past **Hormone replacement, IUD or hormone injections:** yes / no
Menses blood color/quality: bright red dark light brown clotted mucus quantity: heavy scanty medium
Symptoms associated with cycle? Date of last menses:

General Exercise (what and how often):_____
Special diet?_____Since:_____
Food cravings?_____
Known allergies/sensitivities: _____
How often do you move your bowels: _____
Problems with digestion? _____
Mood problems?_____
Major sources of stress: _____
How is your sleep? _____

List any other current or formerly frequent symptoms:
Skin/Hair:
Cardiovascular:
Gastrointestinal:
Respiratory/sinus/oral:
Sensory/Nervous:
Urinary:
Musculoskeletal:
Women's health:
Men's health:
Other issues:

Thank you!