



Health History Form - ACUPUNCTURE

WELCOME TO OUR OFFICE - Please complete all requested information. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential, you will be asked to provide written authorization for release of any information.

Name:			Date:		
Address:		Apt #:	City:		Postal Code:
Tel # (home)		Tel #: (cell)		Tel #: (work)	
Date of Birth: (day/month/year) / /	Age:	Marital Status (please circle): M S D W		Email:	
Medical Doctor's Name (and address & tel number, if known):					
Is this a W.S.I.B. or work related injury?			Is this a result of a motor vehicle accident?		
What is your major complaint?					
Please describe your symptoms:					
What makes is worse?			What makes it better?		
List previous falls, accidents, and injuries:					
List any illnesses and surgeries:					
List any medications you are taking:					
What treatments have you received?					
Have you had x-rays taken within the last two years?			Females: Do you suffer from PMS/dysmenorrhea?		
Have you had acupuncture before?		When?		Why?	
Are you a smoker?		# of cigarettes per day	Recreational activities:		
Occupation:			How did you find out about our office?		
Is there anything else the doctor should be aware of?					
LIST ANY FAMILY MEMBERS WHO SUFFER FROM THE FOLLOWING:					
Arthritis	Cancer	High Blood Pressure		Heart Disease	
Stroke	Diabetes	Other			

Please complete other side