

# HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Name: _____			
Street: _____	City _____	State _____	Zip _____
Age: _____	Height: _____	Weight: _____	Email _____
Home Phone: _____		Work Phone: _____	
Date/Place of Birth: _____		Social Security Number: _____	
Occupation: _____		Marital Status: _____	
In Emergency Notify: _____			
Referred by: _____			
Family Physician: _____			
Insurance Carrier: _____		Policy Number: _____	
Have you tried acupuncture or Chinese herbal medicine before? _____			

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: \_\_\_\_\_

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? \_\_\_\_\_

How long has it been since you first noticed any symptoms? \_\_\_\_\_

Have you been given a diagnosis for the problem by your family physician? \_\_\_\_\_

If so, what is it? \_\_\_\_\_

What kinds of treatment have you tried? \_\_\_\_\_

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES):

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies: _____                                 | <input type="checkbox"/> Cancer _____           |
| <input type="checkbox"/> Diabetes _____                                   | <input type="checkbox"/> Hepatitis _____        |
| <input type="checkbox"/> High Blood Pressure _____                        | <input type="checkbox"/> Heart disease _____    |
| <input type="checkbox"/> Seizures _____                                   | <input type="checkbox"/> Rheumatic Fever _____  |
| <input type="checkbox"/> Surgeries _____                                  | <input type="checkbox"/> Venereal Disease _____ |
| <input type="checkbox"/> Thyroid Disease: _____                           |   |
| <input type="checkbox"/> Other significant illness (describe): _____      |   |
| <input type="checkbox"/> Accidents or Significant Trauma (describe) _____ |   |

Birth History (prolonged labor, forceps delivery, etc): \_\_\_\_\_

OTHER RELEVANT MEDICAL HISTORY: \_\_\_\_\_