



Personal Information and Health History Form

This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you. The more information you provide, the better we will be able to understand your underlying patterns. Please fill out your information as in-depth and accurate as possible.

Patient Name _____ Date _____

Name of Parent or Guardian (if applicable) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell or Work Phone _____

Email address _____

Emergency contact – Name _____

Relationship _____ Address _____

Home phone _____ Work phone _____

Birthdate _____ Age _____

Sex: male female Height _____ Weight _____

Occupation _____

Which activities do you perform at work? _____

Who may we thank for referring you here? _____

Have you received acupuncture before? Yes No

When? _____ With whom? _____

List any allergies or sensitivities to foods, medications, or drugs you have:

1. _____
2. _____
3. _____

Please List any medications you are currently taking:

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Please List any supplements (vitamins, herbs, or other) you are currently taking:

Supplement	Dosage	Reason	How long

Please list any past medical procedures or surgeries:

Surgery	Dates	Reason

Please list any past accidents or injuries:

Accident or injury	Dates	Cause

Other medical history or events of significance: _____

Personal & Family History: Self Father Mother Siblings Grandparents

Age(s) (if living)	_____	_____	_____	_____	_____
Check those applicable:					
Asthma	_____	_____	_____	_____	_____
Alcoholism/Drug Abuse	_____	_____	_____	_____	_____
Alzheimer's	_____	_____	_____	_____	_____
Anxiety/Depression	_____	_____	_____	_____	_____
Appendicitis	_____	_____	_____	_____	_____
Arteriosclerosis	_____	_____	_____	_____	_____
Arthritis (indicate type)	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____
Bronchitis	_____	_____	_____	_____	_____
Cancer (indicate type)	_____	_____	_____	_____	_____
Chicken Pox					
Diabetes	_____	_____	_____	_____	_____
Eating Disorders	_____	_____	_____	_____	_____
Emphysema/COPD	_____	_____	_____	_____	_____
Fibromyalgia	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Hepatitis (A, B, C)Herpes	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
HIV	_____	_____	_____	_____	_____
Hypoglycemia	_____	_____	_____	_____	_____
Intestinal parasites	_____	_____	_____	_____	_____
Irritable Bowel Syndrome	_____	_____	_____	_____	_____
Lyme Disease	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Shingles	_____	_____	_____	_____	_____
Sinus Infection	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Multiple Sclerosis	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Thyroid Disorder	_____	_____	_____	_____	_____
Reproductive issues	_____	_____	_____	_____	_____
Irritable Bowel Syndrome	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Ulcers	_____	_____	_____	_____	_____
Whooping Cough	_____	_____	_____	_____	_____
Others - specify - _____					

Do you have a pacemaker or any other metal devices inside your body?

Yes No If yes, which one and where? _____

Please list each health concern by matter of importance for which you are seeking treatment for today:

1. _____

Are you under the care of a physician for this? _____

When did this problem begin? _____

Describe the quality/symptoms of this problem? _____

2. _____

Are you under the care of a physician for this? _____

When did this problem begin? _____

Describe the quality/symptoms of this problem? _____

3. _____

Are you under the care of a physician for this? _____

When did this problem begin? _____

Describe the quality/symptoms of this problem? _____

Do you follow a diet of any kind? If so, please specify _____

Do you eat 3 meals a day? Please indicate the types of foods you eat:

Breakfast: _____

Lunch: _____

Snacks: _____

Dinner: _____

Dessert: _____

Cravings: _____

For women: (Please check any that apply)

Are you, or could you be pregnant? _____ If so, how far along? _____

When is your due date? _____

Number of pregnancies _____ Births _____ Abortions _____ Miscarriages _____

What form of birth control do you use? _____

What form of birth control have you used in the past? _____

Do you have regular PAP smears? _____ How Often? _____

When was your last PAP? _____ Results? _____

Have you ever had an abnormal PAP? _____ If so, what was the result? _____ When? _____

Have you ever had any gynecological surgeries or any abnormal findings on any tests? _____

Do you perform monthly breast exams? _____ Regular Mammograms? _____

Approximate Date of last breast exam by a Doctor/Nurse: _____

Results _____

Age of first menses _____ Age of menopause, if applicable _____

Do you bleed between periods? _____ Do you bleed after intercourse? _____

Are your periods uncomfortable or painful, either emotionally or physically? _____

Is your cycle?:

Short (Less than 28 days) _____ Long (28+ days) _____ 28 days _____ Irregular _____

How many days do you bleed? _____

Is your period painful? If so, Before _____ During _____ After _____

Do you bleed heavily? _____ Moderately? _____ Lightly? _____

Do you have clots? _____ If so, when? _____

Relative to the blood that comes from a wound, is your menstrual blood:

The same color _____ More pale _____ Purple _____ Red _____ Brown _____

Do you have any of the following Pre-Menstrual Symptoms?

Irritability _____ Depression _____ Crying _____ Anger _____ Pain _____

Any other symptoms around the time of your period? _____

Do you have any other gynecological concerns or complaints? _____

For men: (Please check any that you experience now or have in the past:

Approximate Date of last Testicular exam by a doctor/nurse: _____

Results _____

Approximate Date of last PSA test: _____

Results _____

Do you have any other concerns? _____

Appointment slots are not double-booked, so a late cancellation or missed appointment means a treatment opportunity may go unfilled. Cancellations made less than 24 hours prior to the appointment time and all missed appointments may be charged \$20.

I have provided correct and complete information to the best of my knowledge.

Patient's or Guardian's signature

Date

******Please include copies of any lab work you have.***