Health History Questionnaire

Patient Name: _____Date: _____

Gender: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Can We Text you to confirm appts? _____

Occupation: _____ Employer: _____

Hours worked per week: _____ Best Appointment Days & Time _____

How did you hear about office? _____

Chief Complaints:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Medical Diagnoses:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medications: (include start date & how long taken)

_____

_____

_____

_____

_____

_____

_____

Supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Lab Values/Testing:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Married? Y/N, How long? _____, Is your current family supportive? Y//N

Children, Age, additional information:_____

#1: Major Complaint: _____ When did start? How often? Scale: ___/10, Quality? What have you tried?	
#2: Major Complaint: _____ When did start? How often? Scale: ___/10, Quality? What have you tried?	

Review of Symptoms

General: _____

EENT: _____

Immune/Allergies: _____

Cardio/Vascular:_____

Gastro/Digestion:_____

Urinary: _____

Bowels: _____

Menses: _____

Sleep: _____

Energy: _____

Pain: _____

Mental/Mood:_____

Current Diet: _____

Current Exercise: _____

Current Mind-Body Spirit Practice: _____

How does your current health issues affect your life: work, relationships, extracuricular activity?

What hobbies or activities would you resume if you felt better?

How committed are you to getting your health under control (1-10): _____

Is there anything that would prevent you from treatment?

What have you heard about Acupuncture? _____

PHYSICAL STRESSORS – Please include Dates (if possible, put in date order of occurrence)	
ACCIDENTS	Car Accidents: Falls/Trips/Sports: Other Accidents:
BROKEN BONES	
SURGERIES	# Pregnancies: # Births: #Abortions:
SCARS/ STITCHES	
INFECTIONS/ Major	

CHEMICAL STRESSORS	
Profession	
Radiation Exposure	
Mold Exposure	
Food, % Organic	
Substances	Medications: _____ Street Drugs: _____ Alcohol: _____, Smoking: _____, Caffeine:_____
Dental Interventions	Amalgam fillings:
Other Exposures	

PHYSCOLOGICAL STRESSORS	
How was childhood?	
Relationship Mom	
Relationship Dad	
Work/Finances	
Marital Status	
Children	
Other	

The combination of physical, chemical and psychological stress on the body over a lifetime leads to imbalances in the mind-body-spirit over time. This long standing imbalance leads to symptoms and eventually disease. It is my job to find where these imbalances are in your body and based on your specific needs develop a plan to correct them.