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Health History Questionnaire

Welcome! To help me provide you with the best possible care, please fill out this form. All the information will be kept confidential in your patient file.

Name: _____ Date: _____
Home Phone: _____ Cell Phone: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Email: _____
Date of Birth: _____ Who referred you: _____

Employer: _____ Occupation: _____
Work Phone: _____Address: _____
Insurance Carrier: _____ Name on Plan: _____
Member/Subscriber ID: _____ Group ID: _____
SS# number: _____ If it was due to an accident was it at work ____ or a car accident: ____ Name of auto insurance co.: _____
Date of injury: _____ Where and how injury occurred: _____
_____
Claim number: _____Adjuster's name: _____
Phone: _____ Address: _____

For information only. No contact will be made without your permission:
Name of your main health care provider: _____
Form of medicine: _____Phone: _____ Date and reason for last visit:_____
Other provider: _____
Form of medicine: _____Phone: _____ Date and reason for last visit:_____

What are your chief complaint(s)?: _____
_____
_____
When did it/they begin? _____ Is it getting better or worse?: _____
What kind(s) of treatment have you tried, and have they been helpful? _____
_____

Please list past medical problems: _____

_____

_____

Surgeries: _____

Childhood illnesses: _____

Please check all the boxes that are now or have been a part of your health history:

- ❑ arthritis
- ❑ allergies
- ❑ anemia
- ❑ bleeding/bruising
- ❑ high/low blood pressure
- ❑ cancer, lumps, tumors
- ❑ diabetes
- ❑ digestive disorder
- ❑ dizziness
- ❑ emotional unrest
- ❑ eye, ear, nose
- ❑ fatigue
- ❑ genital problem
- ❑ headaches
- ❑ heart disease
- ❑ hypoglycemia
- ❑ injuries
- ❑ insomnia
- ❑ kidney disorder
- ❑ lung related disorder
- ❑ ob/gyn difficulties
- ❑ pain or numbness
- ❑ rapid weight gain/loss
- ❑ seizures
- ❑ skin problems
- ❑ urinary disorder
- ❑ other

Current medications, including vitamins, herbs, and other supplements.

_____ dosage: _____ for how long: _____

_____ dosage: _____ for how long: _____

_____ dosage: _____ for how long: _____

_____ dosage: _____ for how long: _____

Any known allergies: _____

Do you have or have you been exposed to: HIV/AIDS _____

Hepatitis _____

Other information that is important for me to know? _____

_____

In case of emergency, contact: _____Relation: _____

Phone: _____ Address: _____

Office Policy: All fees for medical services are due at the time of each treatment. If you have insurance which covers acupuncture, I will be happy to assist you in preparing your claim. If you need to cancel an appointment, please give a minimum of 24 hours notice to avoid cancellation fees. Date:_____ Signature: _____