HEALTH HISTORY QUESTIONNAIRE

Please help me 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 my attention that is not asked on this form, please note it in the Comments section. **Thanks**

NAME:		PHONE: H	W	/		
ADDRESS:		CITY:	STATE: _	ZIP:		
AGE: DATE O	FBIRTH:	PLACE OF BIRTH:				
E-MAIL:	(S	ee Privacy Policy)	HEIGHT:	_WEIGHT:		
EMPLOYER NAME:		OCCUPATION:				
FAMILY PHYSICIAN: _		REFERRED BY:				
IN EMERGENCY, NOT	IFY:	T:PHONE:				
HAVE YOU BEEN TRE	ATED BY ACUPUNCTUR	E OR ORIENTAI	L MEDICINE BEG	ORE? YES NO		
Main problem(s) you wou	ald like help with:					
How long ago did this pro	oblem begin (be specific):					
To what extent does this j	problem interfere with your	daily activities (w	ork, sleep, sex):			
Have you been given a di	agnosis for this problem? If	so, what:				
What kinds of treatments	have you tried:					
Past Medical History (ple	ease include date): Cancer		Diabetes _			
Hepatitis	High Blood Pressure	·	Heart Disea	ase		
Rheumatic Fever	Thyroid Dis	sease	Seizures			
Venereal Disease	Other					
Surgeries (type and date):	:					
Significant Trauma (auto	accidents, falls, etc.):					

Significant Dental Work (type and date):					
Birth History (prolonged labor	or, forceps delivery, etc.):				
Allergies (drugs, chemicals, f	foods, reaction):				
Family Medical History (chec	ck): Diabetes Allergies Seizure High Blood Pressure Stroke A Other	Asthma Cancer			
	steroids?Yes No st two months (vitamins, drugs, herbs, etc.):				
Do you have a regular exercis	se program? Yes No Please describe	e:			
Have you ever been on a restr	ricted diet? Yes No what kind?				
Afternoon: Evening: How many packs of cigarette How much coffee, tea, or cold How much alcohol do you dr	s do you smoke per day?a do you drink per week?				
	CHECK ANY YOU HAVE HAD IN THE LAST THRI	EE MONTHS			
MEUROPSYCHOLOGICAL Seizures Areas of numbness Weakness Sleep disorders Concussion Bad temper	Depression Easily susceptible to stress Loss of balance Poor memory Anxiety Substance abuse	Have you ever been treated for emotional problems?Have you ever considered or			
Loss of control/violence Vertigo Lack of coordination	Other neurological or psychological problems	attempted suicide? Yes No			

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