Health History Questionnaire

Name_____ Date_____

Phone: home_____work_____cell_____

E-mail_____

Address_____

Sex M F Date of Birth_____age___ (if known)time & place_____

Referred by:_____

Occupation_____

Emergency Contact:_____

Do you have Insurance that covers Acupuncture?_____

If Yes: Company_____ID#_____Group#_____
Company Phone #_____

What is/are the main problems you would like help with?

How long ago did this problem begin? Was it a gradual or sudden onset?

To what extent does this problem interfere with your daily activities?

What kinds of treatment have you tried? Did you get relief?

Past Medical History (please include the dates)

Cancer	Diabetes	Hepatitis
High Blood Pressure	Heart Disease	HIV/AIDS
Thyroid Disease	Seizures	Migraines

Surgeries: (type of and date)

Significant Trauma (auto accidents, falls, etc.)

Allergies (drugs, chemicals, foods, etc. Result)

Please indicate usage per day or per week:

Cigarettes_____ per_____ Tea_____per_____
Alcohol_____per_____ Soft Drinks_____per_____
Sugar_____per_____ Coffee_____per_____
Water_____per_____

Prescription Drugs:

Supplements:

Do you crave any flavors or food?

Please describe a typical daily diet:

Breakfast Lunch Dinner Snacks (what time)

Digestion: Please circle the following:

diarrhea constipation gas bloating appetite - high/low

Frequency of bowel movements?

Sleep:

How many hours/night do you get? How many do you like to have?

Difficulty getting to sleep? Staying asleep?

Do you feel rested upon waking?

Women:

Last menstrual period: How long between periods?:
Please describe the flow:

PMS - please describe emotional or physical, symptoms and duration.

Menopause - Please describe your current menses/when they stopped, any menopausal discomfort:

Emotional:

Occupational Stress (chemical, physical, psychological, etc.)

Have you experienced:

Depression Anxiety Panic Attacks Mental disorder

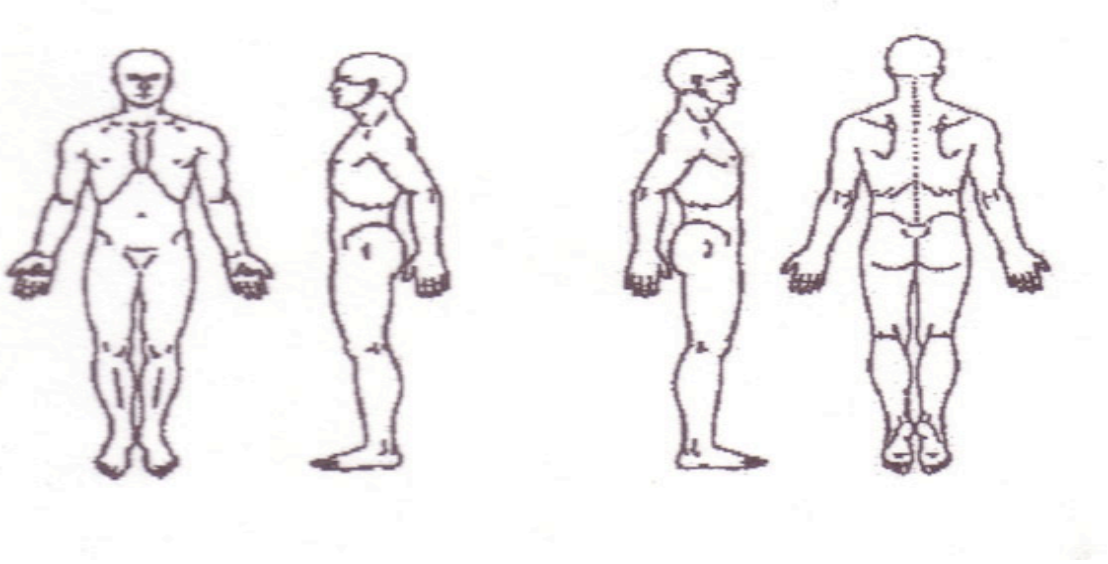
Addiction To what substances?

What is your primary emotional state?

What is your favorite climate and season?

Do you have a regular exercise program? Please describe:

Please indicate any areas of pain:



Cancellation Policy

I agree to give a 24 hour notice if I need to cancel an appointment. This allows time for another person to be contacted and take the scheduled time. There are allowances for emergencies, otherwise I agree to pay for the scheduled appointment. If payment is usually made by my insurance company I agree that I will be responsible for direct payment in case of a missed appointment.

Name_____date_____

In the case of the practitioner missing an appointment or “double booking” there will be no charge for the following appointment.

Jeya Aerenson, OMD, L.Ac.