Health History

1. Have you ever had an acupuncture treatment? When and for what reason?

_____

_____

2. Are you presently being treated for a medical condition(s)?

_____

_____

3. Please describe date of injury and/or onset of illness:

_____

_____

4. Please describe any chronic pain:

_____

_____

_____

_____

5. What health issue do you want treated? Please describe as fully as possible.

_____

_____

_____

6. What medical procedures have you been using for relief of this issue? (ie, physical therapy, chiropractor, steroid injections, massage; please list supplements and medications in the Supplements and Medications Section)

_____

_____

7. Do you have other health concerns or goals for your well being?

_____

_____

_____

_____

8. Please list any hospitalizations, the reason and procedures (i.e. surgery etc.), and the date of the hospitalization:

_____

_____

9. **ARE YOU CURRENTLY PREGNANT?_____IF YES, HOW LONG_____**

Please describe your pregnancy history (i.e.number of pregnancies, completed, incomplete etc.)_____

Diet, Exercise, Medications

Please describe the type of foods you eat regularly:

Breakfast_____

_____

Morning Snack_____

Lunch_____

_____

Afternoon Snack_____

Dinner_____

_____

Evening Snack_____

Do you exercise regularly? Yes ____ How often? ____ No ____

What type of exercise do you do?

_____

_____

Please list any food allergies and sensitivities and their onset:

_____

_____

_____

_____

DRUG ALLERGIES:_____

Latex allergy?_____

SUPPLEMENTS AND MEDICATIONS

Include herbs in all forms (teas, pills, powders), pharmaceuticals prescribed or over the counter, diet therapy (including fasting and cleanses) especially if used to treat or prevent current or past health issues

Date Started	Name of Supplement or Medication	Frequency of use	Treatment or prevention goal