Health History Questionnaire

It is of great benefit to your healing process if I have a good sense of the condition of your overall health. All of the answers will be held in complete confidence and can never be shared except by specific consent of you or your physician.

Name: _____

Date of birth: _____ Age: _____ Height: _____ Weight:____

Home Phone: _____ Cell : _____ Work; _____

Email Address: _____

Occupation: _____

What are we treating? _____

Any previous experience with Acupuncture? _____

When did your symptoms come on?_____

Do you have a medical diagnosis? _____

What is the diagnosis? _____,

What if any treatments have you received in the past for this condition?
_____

Are you still receiving these treatments? _____