Mind & Body
ACUPUNCTURE

Health Questionnaire

Name:_____ Date:_____

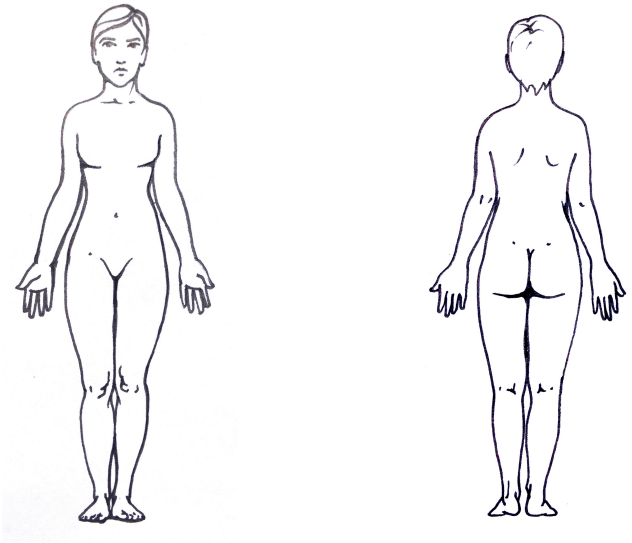
1. Please identify the health concerns that have brought you to the clinic.

Main Condition	
Other health concerns	

2. What lab work have you had done (X-ray, blood work, MRI, CT scan, etc.)

Please include copies: _____

3. Mark where you feel pain or discomfort: **X**=mild **XX**=moderate **XXX**=severe



4.How many hours of sleep do you get in an average night? _____

-Do you have difficulty falling asleep? Y N

-Do you have difficulty staying asleep? Y N

5. Do you have any reason to believe you may be pregnant? **Y N**

6. If so, how far along are you? _____

7. Please list any surgeries and corresponding dates _____

_____

8. Please list any other serious injuries or illnesses _____

9. Medications, Homeopathics, and Supplements you are currently taking:

Medication	Dosage	Reason for taking	How long	Prescribed By	Date last seen

10. Recreational Substance Use:

History of Smoking? **Y N** If so, how long ago and how many per day? _____

History of Drinking? **Y N** If so, how many per week? _____

History of Recreational Drug Use? **Y N** If so, what kind and how often? _____

11. Please list any allergies or drug/food sensitivities _____

12. When was the last time antibiotics were taken? _____

13. Dietary History:

Typical Breakfast	
Typical Lunch	
Typical Dinner	
Typical Snack	

14. How many 8oz. cups per day:

Water_____ Caffeinated Tea _____ Coffee_____ Soda_____

15. What kind of regular exercise do you do? _____

16. How would you describe your energy level? _____

17. Do you tend to run (please circle one): HOT NEUTRAL COLD