PAN SOMA ACUPUNCTURE

HEALTH HISTORY QUESTIONNAIRE

Please take the time to fill out this questionnaire. *All of your answers will be held absolutely confidential*. If you have questions, please ask.

Name_____**Date**_____

Street_____**City**_____**State/Zip**_____

Home Phone_____ **Work Phone**_____ **eMail** _____

Age_____**Date of Birth**_____**Male**_____**Female**_____**Height**_____ **Weight**_____

Occupation:_____**Retired:**_____**Disabled:**_____**Unemployed:**_____

Family Physician:_____**Referred by**:_____

Emergency Contact:_____ **Emergency Contact Relation to you:**_____

Emergency Contact telephone:_____

Have you ever been treated by acupuncture or Oriental medicine before? ☐ Yes ☐ No

Main Problem you would like us to help you with:_____

_____

_____

_____

_____

_____

How long ago did this problem begin? Please be specific: _____

_____

_____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

_____

Secondary Complaints:_____

_____

_____

_____

Please indicate any painful or distressed body areas by circling the particular area: