Medical History Questionaire and Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email: _____

Occupation _____ Person Responsible for your Account _____

Who should we thank for referring you to this office? _____

SEX: ❑ Male ❑ Female ❑ Other Height _____ Weight _____ Birthdate _____ Age _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Domestic Partner

Number of childred & their ages _____

Have you ever received acupuncture therapy before? ❑ Yes ❑ No

If yes, when? _____ With whom? _____

Have you ever taken Chinese herbs before? ❑ Yes ❑ No

Do you have any food restrictions? ❑ Yes ❑ No Vegetarian / Vegan / Food Allergies

Please indicate any significant illnesses you or a blood relative (Grandparent, parent, sibling) have had:

Illness	You	Your relative	Approx. Date	Illness	You	Your relative	Approx. Date
Cancer	❑	❑	_____	Diabetes	❑	❑	_____
Hepatitis	❑	❑	_____	Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____	Seizures	❑	❑	_____
Pheumatic Fever	❑	❑	_____	Emotional Disorders	❑	❑	_____
Infectious Diseases	❑	❑	_____	Tuberculosis	❑	❑	_____

List any medications you are currently taking: (Continue on back if necessary)

Medicine	Dosage	Reason	How Long	Prescribed by	Last checkup date

Please indicate the use and frequency of the following:

	Yes	No	Daily Intake		Yes	No	Daily Intake
Coffee / Black Tea	❑	❑	_____	Tobacco	❑	❑	_____
Non-medical Drug	❑	❑	_____	Alcohol	❑	❑	_____
Water	❑	❑	_____	Soda Pop	❑	❑	_____