Acupuncture At Work

Health History Assessment

Some of the information requested may seem unrelated to your condition but may play an important role in diagnosis and treatment. **All information is confidential.**

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work/Cell Phone: _____
Email: _____ Date of BIrth: _____
Emergency Contact*:* _____ Relationship _____ Phone _____
Occupation: _____
Your Physician: _____ Clinic Name/ Phone: _____

Have you had acupuncture before? Yes No _____
How did you hear about us? Friend /Relative _____ Google __ Other _____

Medical History

Please list any major illnesses, allergies, or conditions you now have or have had in the past
_____
_____
_____

Additional Concerns/Conditions:
_____
_____

Medications (prescribed and over-the-counter),supplements or herbs you are now taking or have taken in the last two months:
_____
_____

Surgeries or hospitalisations and corresponding dates_____
_____

Is there anything else we should know? _____
_____

Women: Where are you in your menstrual cycle? (count from your previous first day of bleeding)
Are you pregnant? _____ If so, how far along are you? _____ Due date _____
Number of pregnancies/live births _____ Dates _____
Miscarriages _____ Dates _____