Health History Questionnaire

Name _____ **Date**_____ **Preferred Pronouns** _____

Mailing address _____**City** _____ **State** _____ **Zip** _____

Phone ____ - _____ - _____ **Email** _____ **Date of Birth** _____ **Age** _____

Emergency Contact _____ **Relationship** _____ **Phone** ____ - _____ - _____

Do you agree to receive email, text, or phone messages to schedule appointments and coordinate care? Yes/No

Have you ever received Acupuncture? Yes/No **Have you used Chinese herbs?** Yes/No

Main health concerns/goals in order of importance to you:

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

Biomedical diagnoses made by physician: _____

_____

Primary Physician Name: _____ **Office Name:** _____ **Phone:** ____ - _____ - _____

Insurance

Insurance Provider _____ **ID #** _____ **Group #**_____

Subscriber Name_____**Subscriber's Date of Birth**_____

Current Medications, Herbs, Supplements

1.) Name_____ Reason _____ Dose _____per _____ Date began _____

2.) Name_____ Reason _____ Dose _____per _____ Date began _____

3.) Name_____ Reason _____ Dose _____per _____ Date began _____

4.) Name_____ Reason _____ Dose _____per _____ Date began _____

5.) Name_____ Reason _____ Dose _____per _____ Date began _____

Are you allergic to scents? Yes/No; **If yes, which ones?** _____