Acupuncture New Patient Questionnaire

Name _____ Date _____

Gender M / F Height _____ Weight _____ Birth Date_____

Occupation _____ Referred by _____

Emergency Contact _____Phone _____

Reason for Your Visit _____
_____

Medical History

Primary Physician _____ Phone _____

Current Medications, Vitamins, Herbs _____
_____

Please indicate any of the following conditions that apply to your health history

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart PX
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ MS
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Surgeries _____
  _____
  _____
- Major Trauma_____
  _____
  _____
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (specify)
  _____
  _____

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