

THE COMMUNITY ACUPUNCTURE PROJECT OF COLUMBIA CITY

AFFORDABLE HEALTHCARE FOR ALL

Health History Questionnaire - please fill out prior to your first acupuncture appointment

Name _____ **Date** ____/____/____

Date Of Birth ____/____/____ **Best telephone # to contact you (____)** _____

What are the primary health concerns that you want us to address?

1)

2)

3)

Have you had acupuncture before? yes no

Are you currently pregnant or trying to get pregnant? yes no

Health History:

Have you presently or have you ever had any of the following disorders?

Skin problems? If yes, please explain:

Respiratory System Disorders? If yes, please explain:

Emotional or Mental Illness? If yes, please explain:

Headaches or dizziness? If yes, please explain:

Digestive System Disorders? If yes, please explain:

Musculoskeletal/Joint Disorders? If yes, please explain:

Fatigue? If yes, please explain:

Sleep problems? If yes, please explain:

Problems with addictions? If yes, please explain:

Women Only:

Menstrual Problems (including menopausal issues)? If yes, please explain:

Any other health information or concerns you would like to address with us?