This is a confidential questionnaire to help us determine the best treatment plan for you.

Name: _____ Today's date: _____

Home Address: _____ Date of Birth: _____ Age: ___

Phone #: _____ Email Address: _____

Emergency Contact Name and Phone #:

_____

Primary reason for acupuncture visit today, describe briefly:
_____
_____

If your visit purpose is for fertility, do we have permission to contact your reproductive endocrinologist/gynecologist? No/Yes, name of MD _____
Contact info:_____

What treatments have you had for the condition?
_____
_____

Please list any medications, herbs, or supplements you are taking:
_____
_____

Check any of the conditions below that are in your health history:

__Asthma
__Pneumonia
__Tuberculosis
__Gout
__Seizures
__Blood Disorder
__Dental Problems
__Gynecological Disorder
__Depression/Anxiety
__Obesity
__Anorexia/Bulimia
__Pacemaker
__HIV/AIDS(TCell/Viral Load?___)
__Gastrointestinal Upset
__Ulcers
__Diabetes
__High Blood Pressure
__Stroke
__Hepatitis
__Rheumatic Fever
__Herpes (oral/genital)
__Venereal Disease
__Thyroid Disorder
__Heart Disease
__Autoimmune Disorder
__Sexual Dysfunction
__Other:
_____
_____
_____

Have you had any major accidents or traumatic injury (physical or emotional)? Y/N
_____

Please list any surgeries:
_____

List any major medical conditions that exist in your family (parents and siblings):
_____
_____
Food Allergies? _____

Intake of:
Alcohol___/day Coffee /_day Tobacco___/day Tea__/day Water___/day Other substances? (Please answer Yes or No. Do not list.) _____

Type and frequency of exercise:
_____