Acupuncture by Maya

Patient Health History

Name: ____ Date: ____________

Street Address: ____

City: __________________________ State: ________ Zip Code: ____________

Phone: _______________________ Can we leave a message/text: Y N

Email: ________________________________ Date of birth: __________________

Preferred gender: _______ Marital Status: _______

Emergency Contact: ___________________ PH: ____________ relation: _______

How did you hear about us? (please state if someone referred you): _______________

Are you currently receiving healthcare: Y N if yes, who? __________________

If no, when and where do you last receive healthcare? ___________________________

Please identify your primary complaint (s)?

1. ____
2. ____

Please list other health concerns in order of importance:

1. ____
2. ____
3. ____

Please list your medications and over the counter medications that you are currently taking:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

Please list any allergies or hypersensitivities (please include type of reaction):

1. ______________________ 2. ______________________

3. ______________________ 4 . ______________________

Height: ________ Weight: ___________ Past max weight and when? ________________

Most recent Blood pressure reading and when: ______________________

Have you had any imaging/testing (CAT scan, MRI, EKG) please include date, reason, and result: ______________________

Have you ever been hospitalized? Surgeries? (when, why and where): ______________

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Do you have any chronic, infectious disease? ______________________

Do you have any reason to believe you might be pregnant? ______________________

Family history of diseases (please list maternal or paternal): ______________________

____

Do you tend to feel warm or cold? ______________________

How is your energy? ______________________ better in am or pm? __________

Describe your bowel movement; frequency, loose or constipated: ___________________

Describe your mental/emotional condition: ______________________

Describe your sleep condition: ____

Do you smoke: Y N if yes how much: __________________________________

Alcohol: Y N if yes, how much: _______________ recreational drugs: Y N

If yes, how much: ____________________

How much exercise do you get and what kind: __________________________________

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Describe your diet and digestion:____

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Please list any other general concerns we might help you address: ________________

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