

Eastern Ways Acupuncture & Health Center

18731 N. Reems Rd., Suite 640 * Surprise, AZ 85374
(623) 584 – 6200

Health History Questionnaire

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Important information for your Acupuncturist. Please complete this document as thoroughly as possible. All information is strictly confidential.

	Name	Title
Primary Physician	_____	_____
Other Health Care Personnel	_____	_____
	_____	_____
	_____	_____

How did you hear about our center? _____

What prescription medication(s) are you currently taking?

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____
7 _____	8 _____	9 _____

Prescribing Doctor: _____

For what conditions do they treat? *In respective order, please.*

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____
7 _____	8 _____	9 _____

What are the results? _____

What supplements are you currently taking? (vitamins, minerals, herbs, etc.)

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____
7 _____	8 _____	9 _____

What is/are your major complaint(s)? *In order of greatest to least significance.*

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____
7 _____	8 _____	9 _____

How do these conditions impair your daily activities?

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Health History Questionnaire

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What conditions significantly affected your health as a child?

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____
7 _____	8 _____	9 _____

What major surgeries have you had?

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____
7 _____	8 _____	9 _____

What immunizations have you had?

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____
7 _____	8 _____	9 _____

Please indicate if you have or had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Bleeding &/or Blood Vessel Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Polio |
| <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mononucleosis | |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Other Lung Illness | <input type="checkbox"/> Other Heart Illness | <input type="checkbox"/> Other Liver Illness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other Kidney Illness |

Specify "Other" : _____

