VITALITY HEALTH

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Acupuncture - Health Questionnaire

Name:_____**Age:**_____
Last Name First Name

Birthday:_____/_____/_____ **Sex:** M F
day/month/year

Marital Status:_____ **Nationality:**_____

Occupation:_____

Address:_____

_____

_____

Email:_____

Telephone: (home)_____(work)_____

Current Health Concerns:	How long ?

What kind of **treatment** (if any) have you received for the problem(s)?

_____

_____

Are you currently working with a **Medical Doctor**?

Name:_____Phone:_____

Are you currently on any **medications?** (include name, dose and how long you have been on it)

_____ _____

_____ _____

Are you currently on any **vitamins** or **herbal** remedies?

_____ _____

_____ _____

Medical History: (Please provide information for each of the following ie. Dates, details)

- Surgeries:_____Date:_____
- Past Hospitalizations:_____Date:_____
- Accidents/Trauma:_____Date:_____
- Which **vaccines** have you received? (please include approximately when they were last given)

  Hepatitis B_____ DPT_____ HiB (influenza)_____

  Polio (injected or oral)_____Measles/Mumps/Rubella_____

  Tetanus_____ Chickenpox_____ Flu shot_____

*Did you experience any reactions to the above vaccines?

_____

- List of **Medications/ Herbs** taken in the past:

  1._____ 2._____

  3._____ 4._____

  5._____ 6._____

Family History: (Please list age & health problems, or age & cause of death)

	Age	**Health Problems**
Mother	_____	_____
Father	_____	_____
Siblings	_____	_____
	_____	_____
	_____	_____
Grandma(Maternal)	_____	_____
Grandma(Paternal)	_____	_____
Grandpa(Maternal)	_____	_____
Grandpa(Paternal)	_____	_____

Other: (is there anything else I should know about you)