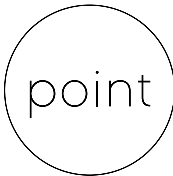

POINT Acupuncture | Asian Medicine

Patient health history

Name:______________________________ Date of Birth:_____/_____/_____

Age:_____ Gender: **M** / **F** Phone Number:________________ Email:________________

Address:______________________________

Emergency Contact/Relation/Phone:______________________________

Your **PRIMARY** condition/complaint:______________________________

Please circle a number of severity of complaint for your **PRIMARY** condition (1=no problem 10= very severe)

1 2 3 4 5 6 7 8 9 10

Past treatment(s) for primary condition:______________________________

Your **SECONDARY** condition/complaint:______________________________

Please circle a number of severity of the complaint for your **SECONDARY** condition (1=no problem 10= very severe)

1 2 3 4 5 6 7 8 9 10

Past treatment(s) for secondary condition:______________________________

Do you have a reason to believe you may be pregnant? **Y** / **N** If so, how far along are you?________________

Do you have a pacemaker or any electrical implantable device? **Y** / **N**

Do you have any infectious diseases? **Y** / **N** If yes, please identify:________________

Please list all known food or drug allergies:______________________________

____

Please list any medications (prescribed and over the counter) you are currently taking:________________

____

____

HOSPITALIZATIONS AND SURGERIES:

Reason:	When:

Anything else we should know? ______________________________

How did you hear about us? ______________________________