CHI HARMONY ACUPUNCTURE

Copley Square ♦ 581 Boylston St, Suite 603 ♦ Boston, MA 02116
Tel: (617) 267-1055 ChiHarmonyAcu@gmail.com W: ChiHarmonyAcu.com

Health History Questionnaire

Welcome to Chi Harmony Acupuncture. Please complete the following form in detail.
All information on this form is strictly **confidential**.

Treatment Date: _____

First Name: _____ MI: ___ Last Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone: Day _____ Evening _____ Cell _____

Email: _____ Occupation: _____

What is your preferred method of communication? (circle one) Day / Eve / Cell / Text / Email

Would you like to receive our E-News with special offers, news and event updates: Y / N

Birth Date: _____ Age: _____ Sex: M / F

Referred By: _____

Emergency Contact: _____ Contact Phone: _____

Primary Physician: _____ Physician Phone: _____

Insurance Provider: _____

Have you ever had acupuncture? Y / N

WESTERN MEDICATIONS

Please list below all of the medications/ supplements/ herbs you take.
I do not take any: ____ Western Medications ___ Supplements/ Herbs

Medication/ Supplement/ Herb	Reason for Taking	Side Effects
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

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WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

O Diabetes	O Stroke/heart attack	O Multiple sclerosis
O Epilepsy/ seizures	O Pacemaker	O Allergies to metal
O Arthritis	O Fibromyalgia	O Chronic fatigue syndrome
O HIV/AIDS	O Hepatitis B	O Hepatitis C O TB

O Cancer: what type _____

O Mental health issues: what type _____

O Allergies: what drugs or substances (plant, animal, environmental)_____

_____

O Other _____

Pregnancy: Are you, or is it possible that you could be, pregnant? Y / N

Hospitalizations/ Surgeries/ Traumatic Injuries (include dates): _____

_____

_____

MAIN CONCERN(S) YOU WOULD LIKE US TO HELP YOU WITH (in priority order)

Please include when the problem began, and any related Western Diagnosis

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

Secondary Concerns: _____