



2006 S. 39th St.
St. Louis, MO 63110
(314) 772-HEAL (4325)

HEALTH HISTORY FORM

PATIENT INFORMATION

Today's Date _____
Name: _____
Address: _____
City _____ State _____ Zip _____

Residential Phone: _____ Business Phone: _____

Cell Phone: _____ *Please circle the preferred phone number for us to use*

Email: _____

Date of birth: ____/____/____ Age: ____ Weight: ____ Height ____
mo day year

Place of birth: _____

Marital Status: Single ____ Married ____ Partnered ____ Widowed ____ Divorced ____

of Children ____ Ages of Children _____

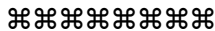
Employer: _____ Occupation: _____

Primary care physician: _____

Emergency Contact Person: _____ Phone # _____

How did you find out about us?:

- Friend _____ Name Health Care Provider _____ Name Internet
- Fair _____ Name Flyer _____ Location Other _____



Chief health concern: _____

How long ago did this problem begin? _____

Have you been given a diagnosis for this problem? _____ If yes, what? _____

To what extent does this problem interfere with your daily activities? _____

Therapies that you have tried in the past for this problem: _____

Are you currently involved in any other therapies for this problem? _____

If yes, which? _____

Is this your first experience with acupuncture? Yes _____ No _____

Name of any herbs or supplements that you are now taking: _____

List any Drugs or Prescriptions you are now taking and why you are taking them.

| Drug | Reason why you are taking Drug |
|------|--------------------------------|
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Please list any surgical or significant scars and their location:

Any significant *past* health crisis or conditions not already mentioned (injury, accidents, serious diseases, etc.):

Any *current* (chronic or acute) health conditions not already mentioned:
