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

HEALTH HISTORY FORM

PATIENT INFORMATION

Today's Date _______________
Name: ____
Address:____
Street City Zip code

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?:____

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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

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:

____
____
____
____
____
____