

Xue Clinic

INITIAL HEALTH HISTORY FORM

Patient Names: First _____ Middle _____ Last _____ Date: _____

What health issue do you want treated? Please describe as fully as possible.

What treatment have you been using for relief of this issue? _____

Have you ever had an acupuncture treatment? When and for what reason? _____

Are you presently being treated for any medical condition? Please describe. _____

Are you taking any medication, herbal remedy, vitamins, or other nutritional supplement at this time? _____

Please circle any illnesses you have ever had:

AIDS/ARC, TB, Hepatitis, Gonorrhea, Syphilis, Genital warts, Herpes: oral/genital, Allergies, Asthma, Anemia, Diabetes, Arthritis, Anorexia, High Blood Pressure, Hay Fever, Insomnia, Rheumatic Fever, Heart disorder, Kidney disorder, Radiation treatment, Prolonged bleeding

Do you have any other health concern? _____

Have you ever been hospitalized for any serious medical illness or operation?

_____ Date _____

_____ Date _____

Are you carrying a pacemaker? Yes ___ No ___ If yes, date placed _____

Are you subject to any nervous disorders, dizzy spells, or fainting? _____

(Woman) Are you pregnant? Yes ___ No ___ If yes, how many months? _____