HEALTH HISTORY QUESTIONNAIRE

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125

Information for your Acupuncturist
Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

Name of your primary physician:____________________

Is there anything limiting you from care ❑Yes ❑No____________________

Other physicians/therapists seen for the condition:____________________

How did you hear about our office:____________________

Medications you are current taking:

1)__________ 2)__________ 3)__________ 4)__________

5)__________ 6)__________ 7)__________ 8)__________

Prescribed by:____________________

For Treatment of:____________________

____

Results:____________________

Supplements (if any, vitamins, herbs, minerals, etc.)____________________

____

Major Complaint(s), in order of significance to you:

1. ____________________
2. ____________________
3. ____________________
4.
5.

Additional:____________________

How do these conditions impair your daily activities?____________________

____

II. **Patient Medical History**

How was your childhood health?____________________

Hospital Visits/Stays: ____________________
Recent tests: (please indicate test results and date below)