

PHILIP KELLEY, LICENSED ACUPUNCTURIST

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Health History Questionnaire

Date: ____ / ____ / ____

- Please help me evaluate your health by filling out this form. Be brief; we will talk in some detail at your first visit.
- All information will be held confidential. Be aware that if an insurance claim is being filed on your behalf, that your insurance company has the right to view your records. Feel free to discuss any other concerns privately.
- If there is anything you wish to bring to my attention that is not asked on this form, additional space is provided for comments at the end.
- Thank you for your trust. I look forward to helping you work toward better health.

Name: _____	Insurance ID Number: _____
Address: _____	City: _____ State: _____
Zip Code: _____	Place of Birth: _____ Date of Birth: ____ / ____ / ____
Home Phone: _____	Work Phone: _____
Sex: ____ Marital Status: ____	Occupation: _____ email: _____
Employer: _____	Insurance Plan: _____
Name of Insured, if other than you: _____	Relationship to Insured: _____
Insured's Date of Birth: ____ / ____ / ____	Auto Accident? Y <input type="checkbox"/> N <input type="checkbox"/>
Your Primary Healthcare Provider _____	Phone: _____
Emergency Contact: _____	Phone: _____
How did you find out about me? _____	
Have you ever been treated by Acupuncture or Oriental Medicine Before? Y <input type="checkbox"/> N <input type="checkbox"/>	

MAIN COMPLAINT

What is/are the problems you would like help with? _____

When did this problem begin? Be specific if possible. _____

What do you think caused it? Is the cause still present? _____

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

Have you been given a diagnosis for this Problem? If so, what? _____

What kinds of treatments have you tried? _____

How severe is your problem right now? (Please mark the scale below):

|_____ |

No problem

Moderate

Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below):

|_____ |

No problem

Moderate

Worst Imaginable

MEDICAL HISTORY

Name: _____ Date: ____ / ____ / ____

Surgeries (type and date): _____

Significant Trauma, auto accidents, falls etc. Include approximate date: _____

Allergies; drugs, chemicals, foods, etc. What reaction do you have? _____

Medicines taken within the past six months, include vitamins, supplements, etc: _____

Occupational stress; chemical, physical, psychological, etc: _____

Lifestyle/emotional stress: _____

Do you have a regular exercise program? Y N Please describe. _____

Have you ever been on a restricted diet? Y N Please describe. _____

Please give a general description of the food you eat during a "typical" day.

Morning: _____

Afternoon: _____

Evening: _____

Before Bed/Between Meals: _____

Habits, how would you describe your average intake of:

	None	Low	Moderate	High
Caffeinated drinks, coffee, tea, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco products:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-prescription (recreational) drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything else you would like to discuss or bring to my attention? _____

