HEALTH HISTORY – ACUPUNCTURE CLIENTS

GENERAL INFORMATION:

Name	Date of Birth (Day/Month/Year)	Sex
Street Name & Number	City	Postal Code
Occupation	Work/Cell Phone	Home Phone

HEALTH CARE PROVIDERS:
Please list any other health care providers you see on a regular bases or have seen recently.

Health Care Provider	Name	Phone
Family Physician		
Physiotherapist		
Chiropractor		
Naturopath		
Other:		

ALLERGIES:
Please list any food, medication, or other allergies you may have.

Substance	Effects and/or Reaction

SURGICAL HISTORY:
Please list any surgeries you have had.

Date	Surgical Procedure

MEDICATIONS, HERBS, VITAMINS:
Please list any prescription and non-prescription medicines, vitamins, minerals, home remedies or herbs you are currently taking, have taken recently or take regularly.

Medications		Herbals		Vitamins	
Name	Dosage	Name	Dosage	Name	Dosage

Today's Date: _____