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

HEALTH HISTORY FORM

PATIENT INFORMATION

Today's Date _______________
Name: ____
Address: ____
City__________________________ State_______________ Zip_________

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?:
□ Friend _______ ___________ Name □ Health Care Provider _____________ Name □ Internet
□ Fair _________________ Name □ Flyer _____________ Location □ Other____________

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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

Please list any surgical or significant scars and their location:

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: