Swan Acupuncture / 311 W. Evergreen Blvd. Vancouver, Washington 98660 / 360-977-0020

Health History Questionnaire

Patient Name________________________________Birth Date_____/_____/_____ M F Circle One
Address____________________________City_______________State_______Zip_______________
Phone____________________________e-mail____
My preferred way to be reached is_____________May we send you our news letter Yes____No____
Referred by__________________________Occupation_________________________________
Reason for seeking treatment____
____**Date symptom(s) started**________________

Circle area(s) of current pain: Head, Neck, Jaw, Shoulder, Arm, Elbow, Wrist, Hand, Upper Back, Lower Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen,
Other_________________________
Circle your pain level: No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present? Constantly___ Frequently__ Intermittently__ Occasionally__
Describe your current health condition Good___ Fair___ Poor___ Chronic___
Can you perform all your daily activities? Yes, all activities___ Some activities___ Not at all___
Are you currently under the care of a physician? No___ Yes___
What treatments, if any, have you received for the condition? (Surgery, Medications, Chiropractic, etc.)____

Please check the appropriate boxes:

Past / Present
____ ____ Alcohol/tobacco/drugs
____ ____ Abnormal menstruation
____ ____ Allergies
____ ____ Angina
____ ____ Arthritis
____ ____ Artificial Joints
____ ____ Asthma
____ ____ Blood disorder
____ ____ Breast Lumps
____ ____ Cancer, Tumor
____ ____ Convulsions/Seizures
____ ____ Diabetes
____ ____ Diarrhea/Constipation
____ ____ Excessive thirst
____ ____ Fainting or Dizziness
____ ____ Rapid weight gain/loss
____ ____ Frequent urination
____ ____ Headache

Past / Present
____ ____ Heart attack
____ ____ Heartburn/Indigestion
____ ____ High Blood Pressure
____ ____ Hospitalizations
____ ____ Surgical procedures
____ ____ Kidney disease
____ ____ Liver problems
____ ____ Pacemaker
____ ____ Painful menstruation
____ ____ Palpitation/arrhythmia
____ ____ Peptic ulcer
____ ____ PMS
____ ____ Pregnancy
If pregnant, how many months along_________
____ ____ Sinusitis
____ ____ Stroke
____ ____ Thyroid

Past / Present
____ ____ Medications
____
____
____
____
____
____
____ ____ Other______________
____

If a close blood relation has had any of the following circle all that apply:

Arthritis
Lupus
Cancer
Heart Disease
Hypertension

Please read and sign:
I, the undersigned, fully understand that no therapeutic treatment, including these, can carry with it any stated or implied guarantee of success. I also understand that these treatments may produce some slight bruising and I release Shoba Satya, Lic Ac. from responsibility in the event that that should occur.
Patient Signature:____________________________________ Date:________________________