Confidential Health Questionnaire

Andréa Silk, MS. L.Ac.

Integrative Wellness Specialist

Personal Information

Client Name: _____ Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip _____

DOB: _____ Home Phone: _____ Work Phone: _____

Occupation: _____ Age: _____ Height: _____

Have you ever received Acupuncture before?: _____ If so, when?: _____

What brings you here today? _____

Is there any area you would like extra time spent? Any area where you have muscle pain/stiffness/tension?

_____

Daily activities/sports/hobbies/exercise: _____

Posture assumed most of the day: _____

Daily water intake: _____ Daily caffeine intake: _____

Average hours of sleep per night: _____ Known allergies (lotion, oil, nuts, etc.): _____

Do you consume any of the following:

☐ tobacco ☐ alcohol ☐ illegal substances

☐ vitamins (please specify): _____

☐ herbal supplements (please specify): _____

☐ over the counter medicines (please specify): _____

Medical History

Please indicate below any significant medical problems that could influence the type or depth of work done in any given area

Skin condition *(acne, rash, allergies, skin cancer, abscess, open sores, other)*: _____

Lymphatic condition *(swollen glands, lymphoma, lymph edema, other)*: _____

Recent injury or accident *(whiplash, sprain, deep bruise, other)*: _____

Circulatory condition *(heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, other)*: _____

Neurological condition *(sciatica, numbness/tingling, stroke, epilepsy, other)*: _____

Joint problems *(osteoarthritis, rheumatoid arthritis, gout, hyper mobile joints, other)*: _____

Bone conditions *(osteoporosis, previous fracture, cancer, other)*: _____

Headaches *(migraines, PMS, tension, cluster, other)*: _____

Emotional difficulties *(depression, anxiety, psychotic episodes, other)*: _____

Stress related disorders *(stomach ulcers, PTSD, other)*: _____

Previous surgery *(Please state type and date)*: _____

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Other Medical Considerations

Do you use any of the following:

☐ contacts ☐ dentures ☐ hearing aids
☐ pins ☐ pacemaker ☐ artificial joints

Blood condition *(hemophilia, HIV, Hepatitis A,B,C,D,E, other)*: _____

Diabetes _____

Asthma _____

Dizziness _____

Are you pregnant? _____

Blood pressure *(high, low)*: _____

Are you under medical care or supervision? *(If yes, please specify)*: _____

Are you currently taking any prescription medications *(name & dosage)*: _____

Have you ever received Chiropractic care? *(If yes, please specify)*: _____

Do I have consent to contact your Health Care Provider or Chiropractor for consultation if needed?

☐ yes ☐ no

Health Care Provider *(DR, PA, APRN)*: _____

Phone number _____

Name of Chiropractor _____

Phone number _____

Client Signature: _____ Date: _____