

Patient Name: _____ **Date:** _____

Major Complaint(s), in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

Severe	Moderate	Slight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do these conditions impair your daily activities? _____

When and how did this condition occur? _____

What treatments have you received for these conditions? _____

Have you ever had an acupuncture treatment? When and for what reason? _____

Are you presently being treated for a medical condition? Please describe: _____

Please briefly describe any chronic pain: _____

What health issue do you want treated? Please describe as fully as possible: _____

What treatment have you been using for relief of this issue? _____

Do you have other health concerns? _____

Please describe the type of foods you eat regularly:

Breakfast: _____

Morning snack: _____

Lunch: _____

Afternoon snack: _____

Dinner: _____

Evening snack: _____

Do you exercise regularly? Yes No

What type of exercise do you do? _____