Patient Name: _____ **Date:** _____

Major Complaint(s), in order of importance to you:	Severe	Moderate	Slight
1. _____	□	□	□
2. _____	□	□	□
3. _____	□	□	□
4. _____	□	□	□
5. _____	□	□	□

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? _____