

# Walla Mountain Acupuncture Confidential Medical History

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (eve) \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Do I have permission to consult with your primary care provider?  Yes  No

In case of emergency, contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please complete both sides of this form as accurately as possible and sign.**

## HISTORY

Have you received acupuncture or taken Chinese Herbs before? Yes  No

Name of Acupuncturist: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_

## MAJOR COMPLAINT

What is your reason for today's visit? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What caused your injury/illness: \_\_\_\_\_

Have you received treatment for this condition?  What type? \_\_\_\_\_

Did previous treatment help? \_\_\_\_\_

## CURRENT HEALTH

Chronic Conditions \_\_\_\_\_

Major or Recent Injuries \_\_\_\_\_

Surgeries with dates \_\_\_\_\_

\_\_\_\_\_  
(For Women): Date of Last Menses: \_\_\_\_\_

Are you currently seeing a health care provider? If so, for what reason? \_\_\_\_\_

\_\_\_\_\_

What do you do for fun or stress relief? \_\_\_\_\_

Do you exercise? \_\_\_\_ How often? \_\_\_\_\_ What type? \_\_\_\_\_

**Circle any of the following conditions that you have or have had in the past:**

AIDS/HIV	Cancer	Hepatitis	Meningitis	Polio	Tuberculosis
Alcoholism	Chicken Pox	Hypertension	Mental disorder	Rheumatic fever	Typhoid fever
Allergies	Diabetes	High fevers	Multiple sclerosis	Scarlet fever	Ulcers
Antibiotic use	Epilepsy	Jaundice	Mumps	Stroke	Vascular disease
Asthma	Glaucoma	Kidney disease	Pacemaker	Thyroid disorders	Venereal disease
Bleed easily	Heart disease	Measles	Pneumonia		

Other: \_\_\_\_\_

**MEDICATION**

Current Medications \_\_\_\_\_

\_\_\_\_\_

List any allergies or sensitivity to any medications or other substances: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

**Circle any of the following conditions that have occurred in any of your relatives:**

Alcoholism	Bleed easily	Diabetes	Heart Disease	Kidney disease	Obesity
Allergy	Cancer	Epilepsy	Hypertension	Mental Illness	Stroke

**Comments/Questions** (Anything else you would like to ask or discuss): \_\_\_\_\_

\_\_\_\_\_

The above information describes my current health to the best of my knowledge. I authorize treatment by the staff of Wallowa Mountain Acupuncture. I understand that I am responsible for payment of all fees to Wallowa Mountain Acupuncture on the day services are rendered unless other arrangements are made in advance.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to treat a minor child:** I hereby authorize Wallowa Mountain Acupuncture to administer treatment to my child (name) \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_