MARIA MITCHELL LAC, MTCM
CLIENT HEALTH HISTORY QUESTIONNAIRE

This is a confidential questionnaire to help determine the best treatment option for you. Please fill out completely and accurately as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Name _____ Age __ Date of Birth _____ Today's Date _____

Home Address _____

If Under 18 Name of Parent or Guardian? _____

City _____ State _____ Zip Code _____

Contact Number(s) Home _____ Cell _____ Work _____

Email Address _____

Emergency Contact _____ Contact Number _____

Were You Referred, If So by Whom? _____

Have You Had Acupuncture Before? Y __ N __ If Yes, Practitioners Name _____

For What Condition (If Yes) _____

Please indicate if any of the following pertain to you. Marking "Yes" does not preclude you from treatment, however (for your safety) it may restrict some of your treatment options.

High Blood Pressure __ Seizures __ Pacemaker __ Blood Thinning Medication(s) __ Pregnancy _

If Yes, please detail _____

Primary Health Concern(s) for your visit today and date first noticed? _____

_____

Your Condition is Improved When _____ Aggravated By _____

On a Scale of 1 to 10, Please Note the Severity of your Main Health Concern Today.
1 2 3 4 5 6 7 8 9 10

On a Scale of 1 to 10, Please Note the Severity of your Main Health Concern to Date.
2 3 4 5 6 7 8 9 10
Have You Been Treated for These Symptoms? Yes __ No __ If Yes, By Whom _____

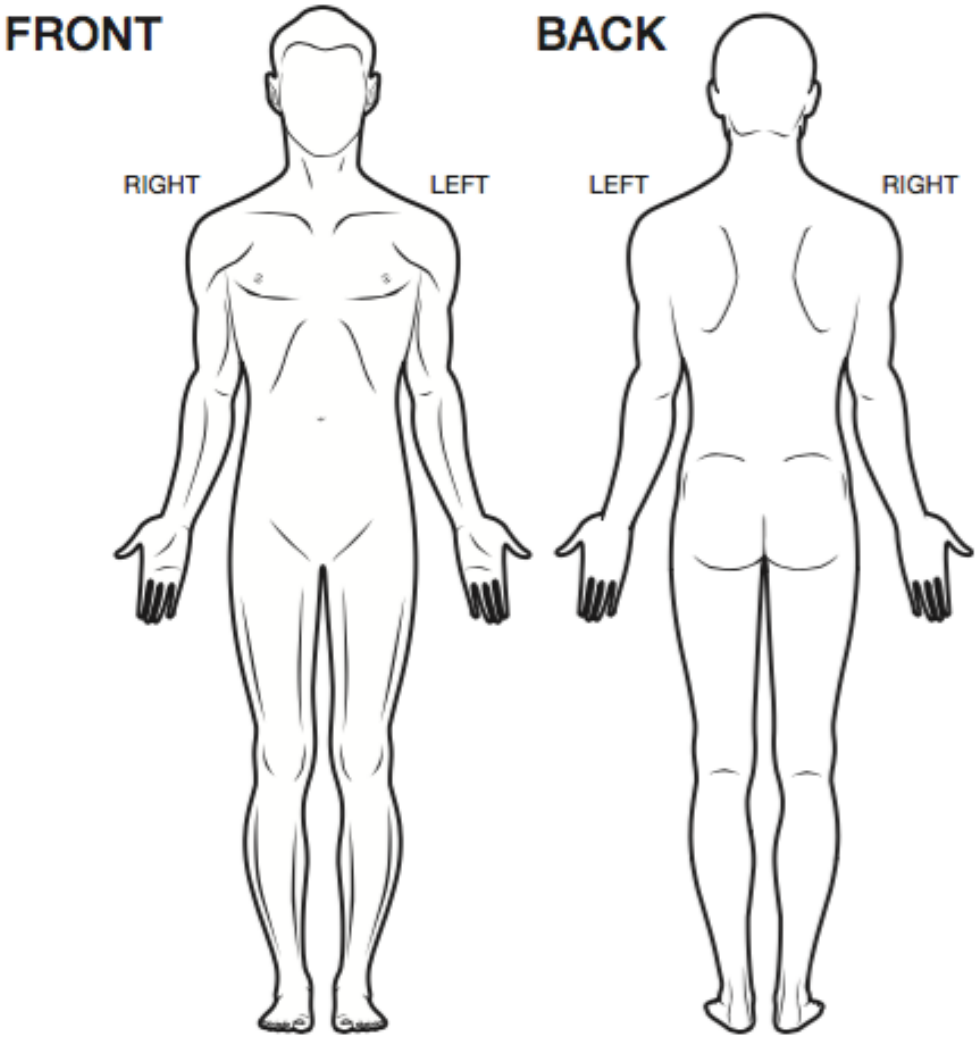
<u>If You Have Pain Currently, Is it:</u>

Aching __ Burning __ Pins & Needles__ Stabbing Pain __ Tightness __

Other _____

Please Mark the Areas of Discomfort or Pain on the Figures Below Using the Symbol That Best Describes the Felling(s)

+++ Sharp or Stabbing **ooo Pins & Needles** **vvv Dull or Aching** **/// Numbness**



<u>Please Check Box that Best Describes Whether Pain or Symptom(s) Limits Normal Activities:</u>

Activity	Normal	Somewhat Limited	Severely Limited
Lifting	___	___	___
Bending	___	___	___
Standing	___	___	___
Walking	___	___	___
Sitting	___	___	___
Climbing Stairs	___	___	___
Running	___	___	___
Resting in Bed	___	___	___
Intercourse	___	___	___
Typing	___	___	___
Normal Work	___	___	___
Household Activities	___	___	___
Recreational Activities	___	___	___

Other (Please List Below)

Please List Any Allergies/Sensitivities, Including Drugs, Foods and/or Environmental:

How Many Courses of Antibiotics Have You Taken (If Any) In the Last 10 Years? _____

Please Check Any That Apply to You or Your Immediate Family Members:

	You	Relative(s)		You	Relative(s)
Allergies	__	__	Kidney Disease	__	__
Asthma	__	__	Lyme Disease	__	__
Anemia	__	__	Lung Disease	__	__
Anxiety	__	__	Obesity	__	__
Arthritis	__	__	Osteoporosis	__	__
Depression	__	__	Seizures	__	__
Diabetes	__	__	Substance Abuse	__	__
Eating Disorder	__	__	Stroke	__	__
Fibromyalgia	__	__	Cancer	__	__
Headaches/Migraines	__	__	Thyroid Disorder	__	__
Heart Disease/Pacemaker	__	__	Transfusion	__	__
Hepatitis A/B/C	__	__	Tuberculosis	__	__
High/Low Blood Pressure	__	__	Other (Please Specify) _____		

Lifestyle & Nutrition

Do You Exercise Regularly? Yes No

What Kind and How Often? _____

Do You Eat At least Three Meals per Day? Yes No

Do You Eat at Regular Times? Yes No

How Much Water Do You Drink Each Day? _____

Dietary Preference(s)

Vegetarian __ Fish/Seafood __ Red Meat __ Eggs __ Dairy __ Fast Food __ Raw Food Diet __

High Protein/Low Carb __ Low Fat Diet __ Whole Foods __ Spicy __ Sweet __ Sour __

Salty __ Bitter __ Cold Drinks __ Hot Drinks __ Warm Drinks __ Extreme Thirst __

Thirst with No Desire to Drink __

Please Indicate Any That Apply to You Now, or In the Past, and Usage Per Day or Per Week: Coffee, Black Tea, Alcohol, Soda, Marijuana, Tobacco, Sugar, Other Recreational Drugs.

How Many Hours Do You Sleep Per Night on Average? _____

I Have Difficulties With:

Falling Asleep __ Staying Asleep __ Dream Disturbed Sleep __ Teeth Grinding/Jaw Tension __

Feel Unrested Upon Waking __ Snoring __ Falling Asleep W/O Medication or Supplement __

Waking Up @ __ AM/PM And Not Able to Fall Back to Sleep.

Please Attach Copies of Any Pertinent Bloodwork/XRAY(s)/CT Scans/Other Studies If Possible.

Please List Any Prescriptions or Over the Counter Medication You Are Currently Taking:

Medication and Dos(s) Reason Prescribed By

Please List Any Herbs/Supplements You Are Currently Taking