Red Bird Acupuncture
Patient Health History

Today's date: _________
D.O.B.________

Name:______________________________Email:______________________________
Address:____
Phone:_________________Cell #______________________Work:________________
Occupation____________________________Physician:__________________________
Current health concerns:____
Duration:____
Other health concerns:____
____
Medications and supplements: [attach list if nessecary]_____________________________
Other treatments or therapies:____

Medical History: Circle those that apply to you, Underline and indicate if in family

AIDS/HIV+
Alcoholism/Drug addiction
Allergies
Asthma
Anorexia/Bulimia
Birth Trauma
Cancer and type:
Dental work
Diabetes
Gall Bladder problems
Heart Disease
Hyper/hypo thyroid
Herpes/Shingles
Hepatitis A/B/C
Hypertension/Stroke
Kidney/Bladder problems
Lyme Disease
Multiple Sclerosis, Parkinson's
Pacemaker?
Polio
Tuberculosis
Ulcers
Rheumatic or scarlet fever
Seizures

Other:____
Significant injuries, surgeries, or illnesses & dates:______________________________
____
Family health history [illnesses, age & causes of death of parents/grandparents]_______
____
____
What sort of exercise do you enjoy and how often ?_________________________________
____
How do you relax ?____

Describe a typical day's meals and drink.

Breakfast:______________________________
Lunch:________________________________Supper:___________________________
Food preferences and intolerances:____
How often do you have: Meat/fish:___________x's a day/week.
Coffee/tea:___________x's day or week
Soda/sweets:_________________x's day or week. Dairy:_____________x's day or week
How many glasses/cups of: Water/day?________Alcohol?:________________
Cigarettes?__________________________

Thanks for your time!