Acupuncture 4 Your Health LLC (A4YH)
Health Questionnaire
28 Bloomfield Ave, Suite 203, Pine Brook, NJ 07058

Date: _____ Patient's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Date/Place of Birth: _____ Email: _____

Height: _____ Weight: _____ Age: _____

Occupation: _____ Marital Status: (M, S,W,D): _____

Emergency Contact: (Name): _____ Phone: _____

Physician (name): _____ Phone: _____

Physician's Diagnosis: _____

Allergies: _____

Main problem(s) you would like to address:

_____

To what extent does this problem affect your daily activities (work, sleep, eating, walk, etc.) _____

When did this problem/symptom first appear? _____

Has there been anything that has ever been able to change your problem in any way? If so, please describe. _____

Is it constant or does it come and go? _____

Have you been given a diagnosis for this problem by a physician or chiropractor? __
If so, what is it? _____

What kinds of treatment or therapy have you tried? (E.g. Epidural shot, Prednisone shot, Cortisone shot, Chiro, Physical therapy … etc)_____

If applicable, does the problem ever move? (For example, pain/spasms/tenderness that occurs in different joints or muscles at different times.) _____

Type of pain, please circle: Fixed, migrating, radiating, achy, burning, dull, electrical, sharp, stabbing, throbbing.

What makes your pain better? Please circle all that apply.

□ Heat □ Cold
□ Pressure □ Massage
□ Movement □ Rest

If applicable, any other ways that alleviates your pain better?
_____

Do **seasonal** changes affect your illness/symptoms? Please describe. _____
_____

Are there other problems you would like addressed?
_____

Are you currently on any **medications**? Please list.
_____

Have you had any surgeries? If yes, what type of **surgery** and when did you have it done?

_____

History of Significant Illness: **Self**: (Please include all past accidents, childhood illnesses, and the date that they occurred)

□ **Hepatitis** □ Rheumatic fever
□ Cancer □ **TB**
□ **Diabetes Mellitus** □ Venereal disease
□ Allergies □ Thyroid disease
□ **High blood pressure** □ Birth trauma (prolonged labor, forceps delivery, etc)
□ **Heart disease** □ Stroke
□ **Seizures** □ Lymph nodes removal
□ **Asthma** □ STD
□ Accidents or significant trauma/illness _____