AWARENESS ACUPUNCTURE, LLC
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Please note, all the following information is private and confidential

Name: _____Date: _____
Address: _____City: _____State: _____ Zip: _____
Phone numbers: Hm: ( ) _____Cell: ( ) _____Wk: ( ) _____
Date of birth: _____Age: _____Sex: Male/Female
Email: _____
Occupation: _____Job title: _____How Long: _____
Employer: _____
Education:_____
_____

Please circle one: Single Married Divorced Widowed Living with:
Personal contact person/relationship: _____Phone number: _____
Physician: _____Phone number: _____
Referred by: _____

Please state *MAIN CONCERN, COMPLAINT OR REASON FOR VISIT*:

_____
_____
_____
_____

Please list any other problems or concerns:

_____
_____

PERSONAL HEALTH HISTORY

Please list and describe any **Diseases or Illnesses**, beginning with the most current:
_____Year: _____ How long: _____
_____
_____Year: _____How long: _____
_____
_____Year: _____How long: _____
_____
Please use the back of this form if necessary

Please list and describe any and all **Surgeries, Hospitalizations, Broken Bones, Traumas or Accidents**. Beginning with the most current:
Type: _____Year: _____
_____
Type: _____Year: _____
_____
Type: _____Year: _____
_____
Please use the back of this form if necessary

Please circle any **Childhood Illnesses** you have had:

Chicken pox
Measles
Mumps
Rubella
Rheumatic fever
Scarlet fever
Whooping cough
Other:

FAMILY HEALTH HISTORY

Please list **Parents** and **Sibling's** names, ages and health history:

Mother: _____Age: _____ Living/deceased: _____
Health hx: _____
Father: _____Age: _____Living/deceased: _____
Health hx: _____
Grandparents: _____Age: _____Living/deceased: _____
Health hx: _____
Grandparents: _____Age: _____Living/deceased: _____
Health hx: _____
Sibling: _____Age: _____Living/deceased: _____
Health hx: _____
Sibling: _____Age: _____Living/deceased: _____
Health hx: _____
Please use the back of this form if necessary

Please list **Children's** names, age, date of birth and health history:

Name:
_____
Name:
_____
Name:
_____

If ***YOU*** or a ***FAMILY*** member has any of these conditions, please *CIRCLE* and note persons name, and year of onset, if known:

AIDS/HIV _____
Alcoholism _____
Allergies _____
Angina/chest pain _____
Arthritis/bone disease _____
Asthma _____
Birth trauma _____
Blood disorder/disease/anemia _____
Cancer/type_____
Diabetes _____
Drug abuse/addiction_____
Depression _____
Emphysema _____
Fibromyalgia _____
Gastric/digestive disorder/disease _____
Heart Disease/disorder _____
Heart pacemaker/valve repair/replacement
Headaches/Migraines_____
Hepatitis A/B/C _____
Herpes_____
Hypertension/High/Low Blood pressure ___
_____

Joint repair/replacement _____
Kidney/renal disease _____
Liver disease/Cirrhosis _____
Lung disease _____
Lymes disease _____
Lymph node removal _____
Mental/emotional disorder/illness _____
Musculo/skeletal disorder _____
Neurological disorder _____
Parkinson's _____
Polio _____
Rheumatic fever _____
Scarlet fever _____
Seasonal allergies _____
Seizures _____
Sinus infections _____
Stroke/TIA's _____
Thyroid disease _____
Tuberculosis _____
Ulcers _____
Other: _____
_____

Please list ALL current Medications:

Name: _____Strength/Dose: _____Frequency: _____Reason: _____
Name: _____Strength/Dose: _____Frequency: _____Reason: _____
Name: _____Strength/Dose: _____Frequency: _____Reason: _____
Name: _____Strength/Dose: _____Frequency: _____Reason: _____
Name: _____Strength/Dose: _____Frequency: _____Reason: _____
Please use the back of this form if necessary

Please list any **Vitamins** or **Supplements** taken:
Name: _____ Strength/Dose: _____Frequency: _____Reason: _____
Name: _____ Strength/Dose: _____Frequency: _____Reason: _____
Name: _____ Strength/Dose: _____Frequency: _____Reason: _____
Name: _____ Strength/Dose: _____Frequency: _____Reason: _____
Name: _____ Strength/Dose: _____Frequency: _____Reason: _____

Are you **Allergic** to any known **Medications**? If yes, please list: _____

Please list all **Current Medical Doctors**:
Name: _____ Phone #: _____ Specialty: _____
Reason: _____
Name: _____ Phone #: _____ Specialty: _____
Reason: _____
Name: _____ Phone #: _____ Specialty: _____
Reason: _____

Please list any **Additional Healing Modalities** used, please circle and note if past or current use:
Massage Cranial Sacral Naturopathic Homeopathic Yoga Therapy Reiki Rolfing
Zero - Balancing Therapeutic Touch Tuning Forks Charka Energy Shiatsu Reflexology
Ayurvedic Shamanic Chiropractic Chelation Other:_____