Mountain Mist Acupuncture

www.mountainmist.me Phone: (828) 263-4132 Fax: (828) 475-5111

Name: _____ **Referred by:** _____

Address: _____

_____

Phone (1): _____ (2): _____

Email: _____

Birthdate:_____ **Height:** _____ **Weight:** _____

Please fill out the following medical history questions as accurately as you can

What is your primary health concern: _____

_____

What is the diagnosis (if any) by an MD: _____

_____

Birth history (any medical procedures or medications?) _____

_____

Vaccination history (any reactions to vaccines? Unusual vaccinations?) _____

_____

Childhood Illnesses (0-12) any surgeries, accidents, major events? Please list in chronological order

Age: _____ _____

Age: _____ _____

Age: _____ _____

Age: _____ _____

Adolescence Illnesses (12-18) any surgeries, accidents, major events? Please list in chronological order

Age: _____ _____

Age: _____ _____

Age: _____ _____

Age: _____ _____

Adulthood Illnesses surgeries, accidents, major events? List in chronological order and indicate duration

Age: _____ _____

_____

Age: _____ _____

_____

Age: _____ _____

_____

Age: _____ _____

_____

Age: _____ _____

_____

Age: _____ _____

_____

Age: _____ _____

_____

Family History: Please note all major illnesses in your immediate family (parents, grandparents), e.g., diabetes, heart disease, hypertension, neurological, blood, psychological, or orthopedic disorders, etc.

_____

_____

_____

_____

_____

_____

Are you taking any medications or supplements? Please note any medications even if you are taking them only occasionally. Also include medications taken in the past. (This includes birth control.)

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____