Vitality for Life
HEALTH CENTER
560 Bryne dr. Unit 1A
Barrie, ON L4N 9P6
705.733.2033
www.vitalityforlife.ca

# Acupuncture - Health Questionnaire

**Name**:_____ **Age**:_____
Last Name First Name

**Birthday**:_____/_____/_____ **Sex:** M F
day/month/year

**Marital Status:**_____ **Nationality:**_____

**Occupation:**_____

**Address:**_____

_____

_____

**Email:**_____

**Telephone:** (home)_____(work)_____

| Current Health Concerns: | How long ? |
|---|---|
| | |
| | |
| | |
| | |

What kind of **treatment** (if any) have you received for the problem(s)?

_____

_____

Are you currently working with a **Medical Doctor**?

Name:_____Phone:_____

Are you currently on any **medications?** (include name, dose and how long you have been on it)

_____ _____

_____ _____

Are you currently on any **vitamins** or **herbal** remedies?

_____ _____

_____ _____

**Medical History**: (Please provide information for each of the following ie. Dates, details)

- Surgeries:_____Date:_____
- Past Hospitalizations:_____Date:_____
- Accidents/Trauma:_____Date:_____
- Which **vaccines** have you received? (please include approximately when they were last given)

  Hepatitis B_____ DPT_____ HiB (influenza)_____

  Polio (injected or oral)_____Measles/Mumps/Rubella_____

  Tetanus_____ Chickenpox_____ Flu shot_____

*Did you experience any reactions to the above vaccines?

_____

- List of **Medications/ Herbs** taken in the past:

  1._____ 2._____

  3._____ 4._____

  5._____ 6._____

**Family History**: (Please list age & health problems, or age & cause of death)

| | **Age** | **Health Problems** |
|---|---|---|
| Mother | _____ | _____ |
| Father | _____ | _____ |
| Siblings | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| Grandma(Maternal) | _____ | _____ |
| Grandma(Paternal) | _____ | _____ |
| Grandpa(Maternal) | _____ | _____ |
| Grandpa(Paternal) | _____ | _____ |

**Other:** (is there anything else I should know about you)