MIDDLE WAY ACUPUNCTURE INSTITUTE PLLC
NATURE-BASED INTEGRATED STUDIES IN ACUPUNCTURE

Please complete the health questionnaire below. All of your answers are completely confidential. The student clinic is a part of the required training for licensure in this state. Therefore, your information will be shared only by authorized faculty members and students. If you have questions, please contact Roland Matthews, Director, at 360-941-0329.

Health History Questionnaire

Name		*Telephone*
Address	*Street*	*City/State/Zip*
Date of Birth	*Age*	*Occupation*
Height	*Weight*	*Family Physician*
Emergency Contact	*Emergency contact Phone*	*Relationship*

Current/Past Medical History (include date)

☐ AIDS/HIV	☐ Emphysema	☐ Mumps	☐ Typhoid Fever
☐ Alcoholism	☐ Epilepsy	☐ Pacemaker	☐ Ulcers
☐ Allergies	☐ Goiter	☐ Pleurisy	☐ Venereal Disease
☐ Appendicitis	☐ Gout	☐ Pneumonia	☐ Whooping Cough
☐ Arteriosclerosis	☐ Heart Disease	☐ Polio	☐ Other (Specify)
☐ Arthritis	☐ Herpes	☐ Rheumatic Fever	
☐ Asthma	☐ Hepatitis	☐ Scarlet Fever	
☐ Birth Trauma	☐ High Blood Pressure	☐ Seizures	
☐ Cancer	☐ Malaria	☐ Stroke	
☐ Chicken Pox	☐ Measles	☐ Tonsillectomy	
☐ Depression	☐ Migraines	☐ Thyroid Disorder	
☐ Diabetes	☐ Multiple Sclerosis	☐ Tuberculosis	

Date of your last Physical Exam_____Results_____

_____

Surgeries/Significant Trauma (include date) _____

_____

_____

Family Medical History

☐ Allergies	☐ Cancer (type_	☐ Heart Disease	☐ Other (Specify)
☐ Arteriosclerosis	_____	☐ High Blood Pressure	_____
☐ Asthma	☐ Depression	☐ Seizures	_____
☐ Alcoholism	☐ Diabetes	☐ Stroke	

Please list medications taken in the last year. Include medications, vitamins, herbs, etc.

_____

_____

_____

Do you exercise? (What type and how often?)_____

Do you smoke cigarettes? (Yes/No) If yes, how many per day?_____Are you pregnant? (Yes/No)

Do you drink alcohol? (Yes/No) If yes, how much per week?_____

How much coffee/tea/cola do you drink per day?_____

Are you under any significant stress? (Yes/No)_____

_____