MIDDLE WAY
ACUPUNCTURE INSTITUTE

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 Joe Rothstein, Executive Director, at 360-336-6129.

Health History Questionnaire

Today's date_____

Name	*Phone Number*	
Address	*City/State/Zip*	
Email	*Occupation*	
Emergency Contact	*Emergency Contact Phone*	*Relationship*

How did you hear about Middle Way Acupuncture Institute?
☐ website ☐ family/friend ☐ advertisement ☐ other:

For communication purposes (appt reminders, etc.), please mark the method(s) you prefer:
☐ cell phone ☐ home phone ☐ email

Have you had acupuncture before? ☐ yes ☐ no

Date of Birth _____ *Age*_____ *Height* _____ *Weight* _____
Family Physician _____ *Date of your last Physical Exam* _____
Results _____
Surgeries/Significant Trauma (include dates) _____
_____
*Reason for visit today:*_____
Please list medications you are currently taking. Include vitamins, herbs, etc. (continue on back if needed)
_____
_____

Personal Current/Past Medical History (include date)

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

Family Medical History

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

Do you exercise? (what type and how often?) _____
Do you smoke cigarettes? (YES / NO) If yes, how many a day? _____ In the past? (YES / NO) _____
Do you drink alcohol? (YES / NO) If yes, how much per? (WEEK / MONTH) _____
Do you take recreational drugs? (YES / NO) Have you in the past? (YES / NO)
How much coffee/tea/cola do you drink per day? _____ Are you pregnant? (YES / NO)
Are you under any significant stress? (YES / NO) _____