MIA ACUPUNCTURE

Date: ___ / ___ / _____

Name:	Sex:	Age:
Address:	City:	State: / Zip Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:
Date of Birth:	Emergency Contact	Emergency Contact Phone Number
How did you hear of our clinic?:	Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ___/___/___	

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: Better no change worse
Damp weather: Better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Check the box if you have / had the condition and note the year it started.
Check the box if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)?	☐		☐
Diabetes	☐		☐
Hepatitis	☐		☐
High Blood Pressure	☐		☐
Heart Disease	☐		☐
Stroke	☐		☐
Seizure Disorder	☐		☐
Thyroid Disease	☐		☐
Asthma	☐		☐
Pacemaker	☐		☐
Osteoporosis	☐		☐
Herpes	☐		☐
AIDS / HIV	☐		☐
Other STD	☐		☐
Rheumatic Fever	☐		☐
Alcoholism	☐		☐
Allergies type(s)?	☐		☐
Mental Illness	☐		☐
Kidney Disease	☐		☐
Anemia	☐		☐

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea		
Soda		
Tobacco		
Alcohol		
Drugs		

EXERCISE

Do you exercise regularly? ☐Yes ☐No

If so, what and how often:

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)