HARBOUR COMMUNITY ACUPUNCTURE LLC

Initial Visit Health History and Intake

Today's Date_____

Name_____Date of Birth_____Phone_____

Email_____Address_____

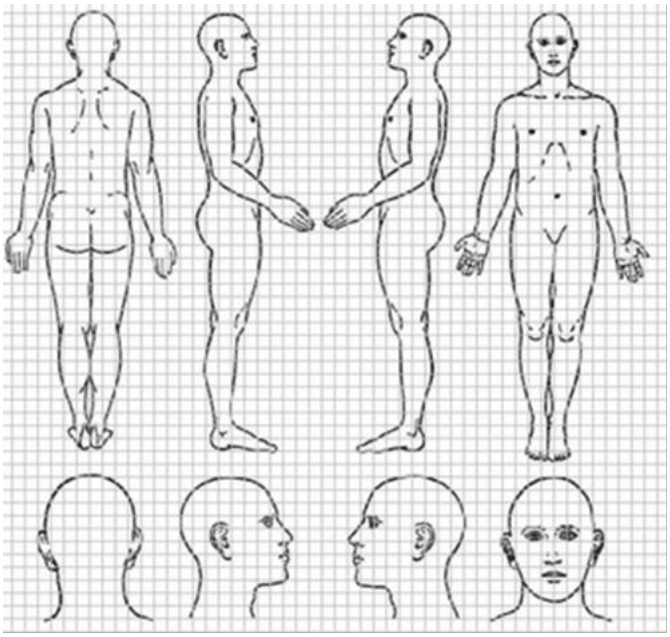
How did you hear about us? _____Have you had acupuncture? Yes / No

List Your Primary Health Concerns (in order of importance to you)	When did this start?
#1	
#2	
#3	

Current Medications/ Supplements_____

Past Major Illness/ Accident/ Surgery _____

Indicate Pain/Areas of Concern:



In the Space below, feel free to tell us more, or to list other conditions/ concerns as needed.

Please check what applies to you:

__Stressed/ overwhelmed
__Difficulty Sleeping
__Anxiety/ nervousness
__irritability/ anger
__Night Sweating
__Edema/ Swelling
__Skin Problem
__Easily Bruised
__Sinus Problem
__Easily Catches a Cold
__Heart Disease
__Breathing Problem
__High/ Low Blood Pressure
__Circulation Problem
__Urinary Problem
__Irregular/Painful Periods
__ Kidney Problem/ Stone
__Gall Bladder Problem/ Stone

__Depressed
__Fatigue
__Hot Flashes
__Headaches
__Migraines
__TMJ
__Eye Problem
__Ear Problem
__Fainting
__Fibroids
__Dizziness
__Coughing
__Palpitations
__Indigestion
__Diarrhea
__Constipated
__Prostate
__Breast lumps

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Signing below indicates that you have completed the form as accurately as possible. Additionally, you understand that it is your responsibility to inform your practitioner of any health changes prior to each treatment. At any time you or your practitioner may refuse treatment.

Signature _____ Date _____