



Health History Questionnaire

Name:

Date:

Address:

City, State, Zip:

Preferred Phone:

Email:

DOB: Age:

Gender:

Occupation:

Employer:

Physician Phone:

Emergency Contact:

Phone:

Relationship to Patient:

How did you hear about Louisville Acupuncture?

Have you been treated by Acupuncture or Oriental Medicine before? ☐ Yes ☐ No

Primary reasons for this visit:

1.

2.

3.