Health History Questionnaire

First Name_____ Last Name _____ MI_____

Address_____City_____ State____ Zip _____

Date of Birth: _____ Emergency Contact Info: _____

Email: _____ Subscribe to newsletter? Y / N Appointment Reminders? Y/ N

Mobile: _____ Primary Care Physician: _____ Who May We Thank for your Referral? _____

REASON FOR COMING TODAY

Chief Complaint:
Describe Symptoms:
When did the symptoms begin?
What makes it better? What makes it worse?
Has a physician given you a diagnosis for this issue?
What kind of treatment or therapy have you tried?
Have you ever been treated with acupuncture, massage, far infrared or halotherapy before? If so, describe:

LIFE STYLE

Stressors in your life:
Describe your diet:
Smoke Cigarettes: | Caffeine: | Alcohol: | Drugs:
Exercise routine:
Do you perform any repetitive movement at work, sports or hobbies?
Do you sit for long hours?
Have you recently had an injury, surgery, or any areas of inflammation? Please describe:
Do you have sensitive skin? Y/ N Latex Allergy? Y/N
Allergies to oils, lotions, or ointments? Y/N (please describe):
Describe any other known allergies:
Medications, Vitamins, Herbs taken in the last 3 months: List name, dose & frequency:

MEDICAL HISTORY

Check any that apply	You	Mother	Father	Siblings	Grandparents
Allergies					
Cancer					
Diabetes					
High Blood Pressure					
Heart Disease					
Stroke					
Substance Abuse:					
Other:					

Provider Notes:

Check all symptoms you have experienced in the last 3 months.

GENERAL		
❒ Poor appetite	❒ Night sweats	❒ Localized weakness
❒ Cravings	❒ Fever	❒ Tremors
❒ Changes in appetite	❒ Chills	❒ Bleeding or bruising easily
❒ Change in weight	❒ Fatigue	❒ Poor balance
❒ Strong thirst	❒ Insomnia	❒ Sudden energy drop Time of day:
❒ Sweat easily	❒ Disturbed sleep	

SKIN AND HAIR		
❒ Rashes	❒ Eczema	❒ New moles
❒ Ulcerations	❒ Acne	❒ Changes in texture
❒ Hives	❒ Dandruff	❒ Other:
❒ Itching	❒ Hair loss	

HEAD, EYES, EARS, NOSE, THROAT		
❒ Dizziness	❒ Color Blindness	❒ Stuffed nose
❒ Concussions	❒ Night Blindness	❒ Runny nose
❒ Headaches	❒ Cataracts	❒ Nose bleeds
❒ Migraines	❒ Blurry vision	❒ Sores on lips or tongue
❒ Facial pain	❒ Eye Strain	❒ Recurrent sore throat
❒ Glasses/poor vision	❒ Ringing in ears	❒ Teeth problems
❒ Spots in front of eyes	❒ Earaches	❒ Jaw clicks
❒ Eye pain	❒ Poor hearing	❒ Grinding teeth
❒ Sinus pressure	❒ Other	

GASTROINTESTINAL		
❒ Nausea	❒ Chronic laxative use	❒ Indigestion
❒ Vomiting	❒ Black stools	❒ Belching
❒ Diarrhea	❒ Blood in stools	❒ Gas
❒ Constipation	❒ Rectal pain	❒ Bad breath
❒ Abdominal pain or cramps	❒ Hemorrhoids	❒ Other

GENITOURINARY		
❒ Frequent urination	❒ Pain upon urination	❒ Kidney stones
❒ Urgency to urinate	❒ Blood in urine	❒ Impotence
❒ Unable to hold urine	❒ Decrease in flow	❒ Sores on genitals
❒ Wake at night to urinate? How often?		❒ Other

RESPIRATORY		
❒ Cough	❒ Difficulty breathing	❒ Pneumonia
❒ Coughing up blood	❒ Pain with deep inhalation	❒ Bronchitis
❒ Asthma	❒Other:	

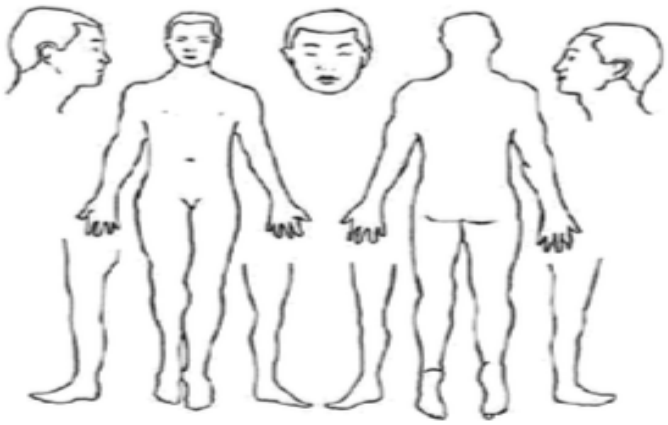
MUSCULOSKELETAL		
❒ Neck pain	❒ Foot/ankle pain	❒ Hip pain
❒ Back pain	❒ Hand/wrist pain	❒ Muscle pain
❒ Knee pain	❒ Shoulder pain	❒ Arthritis
❒ Muscle weakness	❒ Other	

CARDIOVASCULAR		
❒ Dizziness	❒ Cold hands or feet	❒ Blood clots
❒ Low blood pressure	❒ Swelling hands or feet	❒ Other:
❒ High blood pressure	❒ Chest pain	
❒ Fainting	❒ Irregular heartbeat	

NEUROPSYCHOLOGICAL		
❒ Seizures	❒ Poor memory	❒ Easily susceptible to stress
❒ Dizziness	❒ Lack of coordination	❒ Other
❒ Loss of balance	❒ Depression	
❒ Areas of numbness	❒ Anxiety	
Have you ever been treated for emotional problems?		

REPRODUCTIVE AND GYNECOLOGIC		
❒ Premenstrual changes	❒ Heavy menstrual flow	❒ Premature births
❒ Menstrual clots	❒ Light menstrual flow	❒ Miscarriages
❒ Painful menses	❒ Irregular menses	Number of Live Births:
Age at first menses	Age at menopause	Number of pregnancies:
Length of cycle	Duration of bleeding	First day last menses
Do you use birth control? What type?		
Are you pregnant? Y ❒ N❒	Is there a possibility you could be? Y❒ N❒	

Please mark areas of pain, numbness or discomfort below:



I acknowledge and accept the risks inherent in the use of Acupuncture, Massage Therapy, Halotherapy, and the use of Far-infrared Sauna. I voluntarily assume the risk of injury, accident or worse, which may arise from the use of the Massage Therapy, Halotherapy, and the Far-infrared Sauna. I and any of my heirs, executors, representatives or assigns hereby release from all claims or liabilities for personal injury or property damages of any kind sustained while on the premises and from any advice provided by an employee, independent contractor or any representative. I agree that I have reviewed the "Advisements and Contraindications" provided to me by The Health Institute, LLC, and this Intake and Waiver is in effect for all Acupuncture, Massage Therapy, Halotherapy, and Far-infrared Sauna sessions, and will not expire.

Session Cancellation- Clients should cancel their appointment on MindBody, with a minimum of 48 hrs-notice. Log in to MindBody, using the user name and password you used to schedule your appointment, go to "My Schedule" and then cancel your appointment.
Late Cancellation- Clients that cancel their appointment with less than 24-hrs-notice cannot cancel online and should call The Health Institute directly to r/s.
No Shows- Failure to show up for an appointment without advanced notice will result in the forfeiture of the session, and the client will be charged for the entire session.

Printed Name: _____ Signature:_____ Date: _____