A Total Healing Solution

Health History Questionnaire

Name _____
Email: _____
Cell Phone: _____

All information will be kept confidential. Please circle YES or NO:

Yes No 1. Do you have a heart condition? _____
Yes No 2. Do you have an implanted pacemaker? _____
Yes No 3. Do you have any artificial joints or implants? _____
Yes No 4. Do you have any systematic disorders (mononucleosis, hepatitis, etc.) or neuromuscular, musculoskeletal or rheumatoid disorders?
Yes No 5. Are you pregnant? How far along_____
Yes No 6. Have you had a major surgery or illness within the last year?
Please list: _____
_____
Yes No 7. Are you currently taking any medication or prescription drugs?
Please list the medication and its purpose and vitamins: _____
_____Are you taking any blood thinners?_____
_____
_____

Yes No 8. Do you have emphysema, asthma, or any other lung conditions?_____
Yes No 9. Do you carry an inhaler?
Yes No 10. Have you ever lost consciousness or control of your balance due to chronic dizziness?
Yes No 11. Do you have epilepsy?
Yes No 12. Are you or have you ever been treated for a bone or joint problem that restricts you from engaging in physical activity?
What: _____
When: _____
Yes No 13. Is there any physical condition that you have which is aggravated by exercise? Please List: _____
_____
_____
Yes No 14. Are you allergic to anything? _____
Yes No 15. Are you allergic to Stainless Steel? Or any other metal? _____
Yes No 16. Have you every had dry needling or acupuncture before?
Yes No 17. What was your experience? _____
_____

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What are your current goals?

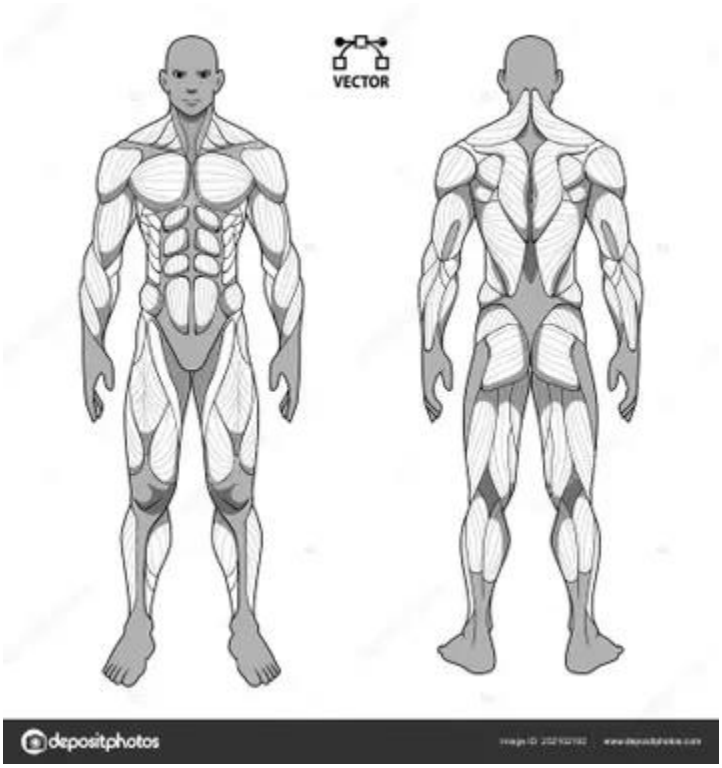
1. _____

2. _____

3. _____

Do you have any pain? _____
How long have you had it? _____
What makes it better? _____
What makes it worse? _____
How does it affect your daily life? _____
Is there anything you would like me to know? _____

Please fill in on the diagram where you have pain.



Name: _____
Date: _____

Signature: _____
_____