Acupuncturist
Sherrie Brooks, LAc.O.M.D.

859 Mosher Ave. • Roseburg, OR 97470 • (541) 229-1583

Health History Questionnaire

NAME_____

ADDRESS_____ _____

CITY_____STATE_____ ZIP CODE_____HOME#_____

YOUR EMPLOYER_____WORK#_____

TYPE OF WORK PERFORMED_____

M_____ F_____ HEIGHT_____ WEIGHT_____ DATE OF BIRTH_____ AGE_____

CIRCLE LIVING SITUATION: Single Married Divorced Widowed Cohabitate Roommates NUMBER OF CHILDREN___

SPOUSE / PARTNER NAME_____WORK#_____

WHO REFERRED YOU TO OUR CLINIC?_____

EMERGENCY CONTACT PERSON OR NEAREST RELATIVE NOT LIVING WITH YOU

NAME_____ NUMBER_____ RELATIONSHIP_____

INSURANCE INFORMATION

Primary Insurance Company_____Phone number_____

Address_____City_____State_____Zip_____

Insured name_____Relationship_____

I.D. #_____Policy #_____Group or Employer_____

FINANCIAL POLICY

BILLING: Payment is due at the time of service; unless other arrangements have been approved of in advance. Pharmacy items such as herbs and supplements must be paid for upon receipt.

Insurance: If your insurance policy covers acupuncture your insurance company will be billed by our office. If you have a deductible that has not been met you are responsible for all office visit fees until the deductible has been met. If you have a co- pay plan you are responsible for paying the percentage you owe at the time of your office visit.

APPOINTMENTS: IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, **24 hours notice is required for cancellation.** IF YOU FAIL TO KEEP YOUR APPOINTMENT OR CANCEL WITHOUT SUFFICIENT NOTICE, THERE WILL BE AN OFFICE VISIT FEE CHARGED TO YOU.

I have read all the above terms and I agree to these conditions.

SIGNATURE_____DATE_____

SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Grating sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

LOW BACK:
- ☐ Low back pain
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ Pinched nerve in low back
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain in mid-back
- ☐ Muscle spasms

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

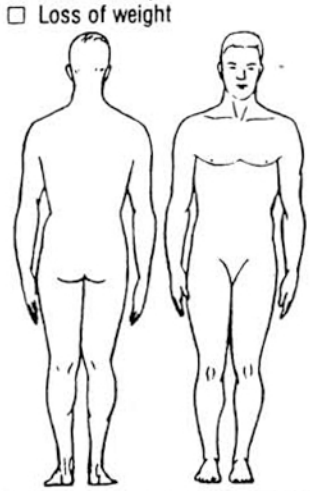
SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Pinched nerve in arm
- ☐ Pinched nerve in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)
- ☐ Painful joints in toes
- ☐ Pain in foot (R-L)
- ☐ Pain in knee (R-L)

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Loss of sleep
- ☐ Loss of weight



MARK AREAS OF PAIN ABOVE

Have you had X-rays before? ☐ Yes ☐ No When? _____

What areas were X-rayed? _____

WOMEN ONLY: Date of last period? _____

☐ Menstrual pain ☐ Cramping ☐ Irregularity

Are you now pregnant? ☐ Yes ☐ No How long? _____

Purpose of this appointment: _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If So: Name _____ Date _____

Date of accident/illness _____ Hour _____ AM _____ PM Location: _____

How did accident occur? ☐ Auto Collision ☐ On-the-Job ☐ Other _____

Please describe the circumstances _____

_____

_____

Have you lost time from work? ☐ Yes ☐ No

Prior surgery _____

Medications taken presently _____

Previous accidents (other than described above) _____

_____

Parents living? ☐ Yes ☐ No In good health? ☐ Yes ☐ No

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