



The Healing Arts Center of San Diego

Personal Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ SS#: \_\_\_\_\_

Whom should we thank for referring you to the office? \_\_\_\_\_

Sex: M  F  Height \_\_\_\_\_ Weight \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Marital Status Married  Single  Divorced  Widowed  Life Partner

Have you received acupuncture before? Y  N  With whom: \_\_\_\_\_

PLEASE INDICATE ANY SIGNIFICANT MEDICAL HISTORY IN YOU OR A BLOOD RELATIVE:

Table with 2 columns of medical conditions and 3 columns for You, Relative, and Date. Includes conditions like Cancer, Diabetes, Heart Disease, etc.

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS THAT YOU ARE TAKING (Continue on back if necessary):

Table with 6 columns: Medicine, Dosage, Reason, How Long, Prescribed by, Date of last check-up.

Please indicate the use and frequency of the following:

Table with 9 columns: Item, Yes, No, How Often, Item, Yes, No, How Often. Includes Coffee, Tobacco, Alcohol, Water Intake.

I certify that my Personal Health History is complete and true to the best of my knowledge. I understand that my medical records are completely confidential and are locked at all times, and compliant with personal health information guidelines under HIPAA. No personal information will be released to any other medical provider without my written permission.

Signature \_\_\_\_\_

Date \_\_\_\_\_