Rootstock ACUPUNCTURE LLC

Health Questionnaire

Today's Date __ __/__ __/__ __
month day year

First Name	Gender	Date of Birth __ __/__ __/__ __ __ __ month day year	
Last Name	Age	Height ' "	Weight lbs

Current State of Health

1. On the line below, please indicate your current state of health and type of care you are seeking now:
   [Acute pain or discomfort _______________ Maintenance _______________ Wellness & Preventative Care]

2. What is/are your primary health concern(s) ____

   ____

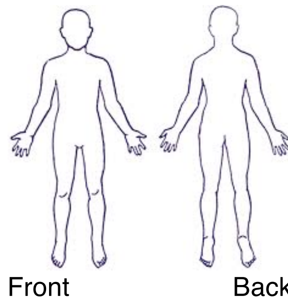
3. How long have you had the condition(s)?____

4. How does it affect your daily activities in work, play or rest? ____________________________________

5. What makes it better or worse? ____

6. If you have any pain, please rate on a scale of 1 – 10 and mark all areas on the diagram.

   Least 1 2 3 4 5 6 7 8 9 10 Most



7. What other treatments/practitioners have you seen for this, if any? ____________________________

Current Habits

1. Typical time you go to sleep: _____ a.m./p.m. Typical time you wake up: _____ a.m./p.m.

2. How many hours do you work per week? _____

3. How many ounces of water do you drink per day? ____ alcohol? ____ coffee? ____ soda? ____

4. Do you smoke cigarettes? ☐ Yes ☐ Have never smoked ☐ No longer smoke

5. Please check how often you do each of the following:	Multiple times a day	Daily	Every other day	Weekly	Less than weekly
Physical exercise					
Meditation					
Play, hobbies, joyful activities					

Medical History

1. Please list significant events you feel impacted your life or health. For example, births, deaths, marriage, divorce, accidents, major illness, surgery, job changes, miscarriages, trauma, anything else.

Age at time

____ ______

____ ______

____ ______

____ ______

____ ______

2. Fill in if this applies to you: "I haven't felt like myself since…." ________________________________

3. Please fill in your typical blood pressure reading: _______/ _______

4. Are you prone to fainting or seizures? ☐ Yes ☐ No

5. Do you have trouble feeling any parts of your body (numbness, etc.)? ☐ Yes ☐ No

6. Please list any known or suspected allergies, sensitivities or addictions to foods/drinks or medications:

____

7. Please list any prescription or over-the-counter medications, vitamins, herbs, etc. you have taken within the last two months:

Item	Dose/ Frequency	Reason for Use	Still taking?

8. Check the illnesses in your family history: ☐ Cancer ☐ Heart disease ☐ Diabetes ☐ Arthritis ☐ Dementia ☐ Mental illness

Other? ____

For Females

1. Is it possible that you are pregnant now? ☐ Yes ☐ No If known, how many weeks? _____

2. When was the date of onset of your last menstrual cycle? __ __/__ __/__ __

3. Do you have concerns about your menstrual cycle or fertility? ☐ Yes ☐ No ☐ Maybe