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Welcome to Serenity Health Arts. To better serve you we ask that you fill out this questionnaire to the best of your knowledge. Do not hesitate to ask if you have any questions. Any information you provide will be treated confidential as required by law.

PLEASE PRINT

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____

Email Address: _____

Birth Date: _____ Age: _____ Height: _____ Weight: _____

Family Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other _____

Referred to our Office by: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Your Occupation: _____

Employment: Full-time ❑ Part-time ❑ Self-employed ❑ Homemaker ❑ Retired ❑ Unemployed ❑ Student ❑

Employer's Name: _____ Employer's Phone #: _____

Employer's Address: _____

City: _____ State: _____ ZIP: _____

Primary Care Physician's Name: _____

Primary Care Physician's Phone #: _____

Primary Care Physician's Address: _____

City: _____ State: _____ ZIP: _____

Health History

What is your main concern that brings you to us today? _____

_____

_____

_____

How long has this been bothering you? _____

Is there anything that makes it better or worse? _____

_____

Have you consulted an MD for this condition? Yes ❑ No ❑ Have you received a medical diagnosis? Yes ❑ No ❑

_____

What treatment(s) are you currently receiving/taking for this condition? _____

_____

Are you experiencing this for the first time or have you had similar episodes in the past? _____

_____

Please tell us about your current health status: _____

_____

Please tell us about your health history, e.g. childhood diseases, fractures, surgeries, hospitalizations, chronic illnesses:

_____

_____

_____

_____

_____

_____

_____

What other treatments are you currently taking? _____

_____

_____

Please list all prescription and over-the-counter medications, herbal products or vitamins you are currently taking:

Type	Name	Doctor	Start	Dosage	Comment

Do you have any allergies? _____

_____

Please describe your diet on a typical day: _____

_____

_____

_____

Do you engage in any physical activity or exercise? How much? How often? _____

_____

_____

Please check any of the habits listed below which apply to you now or in the past.

Coffee	Yes ❑ No ❑	cups per day/week _____	age started _____	age quit _____
Tobacco	Yes ❑ No ❑	cigarettes per day/week _____	age started _____	age quit _____
Marijuana	Yes ❑ No ❑	use per day/week _____	age started _____	age quit _____
Alcohol	Yes ❑ No ❑	use per day/week _____	age started _____	age quit _____
Cocaine/Crack	Yes ❑ No ❑	use per day/week _____	age started _____	age quit _____
Heroin	Yes ❑ No ❑	use per day/week _____	age started _____	age quit _____
Other	Yes ❑ No ❑	use per day/week _____	age started _____	age quit _____

Family Health History: Please place a check mark in each appropriate box.

	Self	Mother	Father	Sister	Brother	Spouse	Child	Other
Allergies								
Blood Disorder								
Diabetes								
Cancer or Tumors								
Seizures								
High Blood Pressure								
Kidney or Bladder Disorder								
Digestive Disorder								
Substance Abuse								
Tuberculosis								
Heart Disease								
Stroke								
Depression / Mental Illness								
Other								
Age at Death	N/A							

Previous Pregnancies:

Total Pregnancies: _____ Live Births: _____ Miscarriages: _____ Induced Abortions: _____

Menstrual History:

When was your first menstruation (menarche)? _____ When did your last menstruation begin? _____

How many days pass from one onset to the next? _____ How many days of flow do you have? _____

How strong is your menstrual flow? _____

What is the color and consistency of your menstruate? _____

Do you have any discomfort or unusual feelings before, during or after your menstruation? _____

_____

_____

_____

Please tell us who you live with:

I live alone ❑ I live with my _____ I have _____ children ages _____

How are you doing emotionally? _____

_____

_____

Have you received acupuncture before? Yes ❑ No ❑ If yes, where? _____

Is there anything else you would like us to know about? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you.