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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: ____

Date of birth: ________________ Age: __________ Height: _________ Weight: _________

Gender: ___________________________ Family status: ____________________

Emergency contact: ___________________ Relationship: ___________________

Emergency contact phone #: ____

Your occupation: ____

Employment status: ____

Primary care physician's name: ______________________________________

Primary care physician's phone #: ____________________________________

Primary care physician's address: ____________________________________

City: ______________________________ State: __________ ZIP: ______________

How did you hear about us? ____

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:

____

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____

____

____

____

____

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? ______________________

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Thank you.