

Simple Balance

"The natural choice"

ACUPUNCTURE • MASSAGE THERAPY

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name _____ Email _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Place of birth _____ Age _____ Height _____ Weight _____

Telephone: Home () _____ Work () _____ Cell () _____

Emergency Contact _____ Telephone () _____ Relationship _____

Single _____ Married _____ Divorced _____ Widowed _____ Living with _____

Education _____ Occupation _____

Referred by: _____

Reason for visit today _____

Other problems _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___ Work ___ other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						