Absolute
HEALTH GROUP

Name________________________________________ Sex M F Date____________________________

Address______________________________________ City____________________ State __________ Zip______________

H. Phone (________) ____________________W. Phone____________________ Date of Birth_________________ Age___________

Referred by________________________________________Social Security #______________________________

Occupation________________________________________ Employer______________________________________

**Have you ever received?**

☐Acupuncture ☐Chiropractic ☐Hypnotherapy ☐Massage Therapy ☐Reiki ☐Reflexology

If yes, when? ______________________________________________________________

**Please indicate if any of the following pertain to you:**
**(Marking "yes" does not make you ineligible for treatment; however, it may restrict some of our treatment modalities):**

☐ Hepatitis ☐ HIV ☐ High Blood Pressure ☐ Seizures ☐ Pacemaker ☐ Blood-Thinning Meds ☐ Pregnancy

**1. Reasons for seeking care:**

Primary reason: ______________________________________________________________

Secondary reason: ______________________________________________________________

**2. Chief Complaint:** ______________________________________________________________

Location of Complaint: ______________________________________________________________

Complaint Began when and how? ______________________________________________________

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _______

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?______________________________

Do you have any numbness or tingling in your body? Where? ____________________________________________

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? ______________________________________________

Does anything aggravate the complaint? ______________________________________________________

Does anything make the complaint better? ______________________________________________________

**3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:** ___________________

______________________________________________________________________________

______________________________________________________________________________

**4. Past Health History:**

**A. Previous illnesses you've had in your life:** ______________________________________________

______________________________________________________________________________

**B. Previous injury or trauma:**______________________________________________________________

______________________________________________________________________________

Have you ever broken any bones? Which? ______________________________________________________

**C. Allergies** ____________________________________________

**D. Medications:**

| Medication | Reason for taking |
| --- | --- |
| | |
| | |
| | |

**E. Surgeries:**

| Date | Type of Surgery |
| --- | --- |
| | |
| | |
| | |

**F. Females/ Pregnancies and outcomes:**

| Pregnancies/Date of Delivery | Outcome |
| --- | --- |
| | |
| | |
| | |

What was the date of the beginning of your last menstrual period? ____________________

**5. Family Health History:**

Associated health problems of relatives: ____________________________________________

Deaths in immediate family:

| Cause of parents or siblings death | Age at death |
| --- | --- |
| | |
| | |
| | |

**6. Social and Occupational History:**

**A. Level of Education:**

O High School O Some college O College Graduate O Post Graduate Studies

**B. Job description:** ____________________________________________

**C. Work schedule:** ____________________________________________

**D. Recreational activities:** ____________________________________________

**E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**____________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office provide me with acupuncture care, in accordance with this state's statutes.

Patient or Guardian Signature ______________________________ Date ______________

Physician/Therapist Signature ______________________________ Date ______________