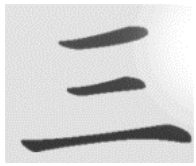


# Patient Questionnaire



**Three  
Harmonies**  
Acupuncture and  
Asian Medicine

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◆  
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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Occupation \_\_\_\_\_ e-mail \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Referred by: \_\_\_\_\_ Date of last medical exam: \_\_\_\_\_

Are you presently receiving other medical treatment?  Yes  No

If so, practitioner's name and phone #: \_\_\_\_\_

Health insurance? Name: \_\_\_\_\_; Policy & Group numbers: \_\_\_\_\_

Address and phone: \_\_\_\_\_

Traditional Chinese medicine requires attention to all symptoms and conditions. Often seemingly-unrelated symptoms are major clues to delicate biochemical / energetic imbalances. Therefore, please complete this questionnaire as carefully as you can. This record of your medical history is confidential and will not be released without your written authorization.

1. What is your main health concern? How long has it been a problem?
2. If you've been treated for this condition before, please briefly describe how and when? What were the results?
3. If you are in pain, please describe its location, frequency, and intensity: (10 = highest, 1 = least). What if anything makes it worse or better?
4. Are there any secondary conditions you would like to have treated?
5. Please list any medications you are taking for these or any other medical condition.
6. Please list any serious childhood illnesses, all hospitalizations and/or surgeries.
7. List any other health issues you've had in the last year (colds, flu, injuries, etc.).