Red Aspen WELLNESS

This is a CONFIDENTIAL questionnaire. Optimal results with successful health care and preventative medicine achieved when the practitioner has a complete understanding of the patient physically, mentally, & emotionally. Thank you.

Today's Date : _____/_____/_____ Email address:_____

Last name:_____ First name:_____

Address: _____

Phone number: _____ Occupation: _____

Insurance: _____ Policy #:_____

Date of birth :_____/_____/_____ Gender: M/F Number of Children _____

Marital Status: ◊ Married ◊ Single ◊ Divorced ◊ Widowed ◊ Civil Union

Who were you referred by ? _____

Reason(s)you're your visit :_____

_____

What other forms of treatment have you sought & what has helped or made this worse?

_____

_____

Have you ever had acupuncture?_____ If so, how long ago? _____

Have you ever taken Chinese Herbs?_____ If so, how long ago?_____

Do you have any infectious diseases? Y N Please identify:_____

Please list any allergies (food, drugs, etc.):_____

_____

Family History:

Check applicable:	Father	Mother	Brother/s	Sister/s	Children	You
Cancer (& type)						
Diabetes						
Heart Disease						
Heart Attack						
Hypertension						
Mental Illness						
Headaches						
Stroke						
Anemia						
High Cholesterol						
Asthma						
Smoker						
Thyroid Disease						
Chicken Pox						

Other:_____

What supplements are you taking and for what? _____

_____

_____

_____

Medication Reason How Long:_____

_____

_____

_____

Do you enjoy what you do/study? _____

When you get sick, what do you tend to get sick with (Stomach aches, flu, sore throats) ?

_____

Exercise and/or fun routine: _____

_____