Ned A. Holle, L.Ac. Dipl. Ac. MTOM
7400 Metro Blvd., Suite 370, Edina, MN 55439
Office: (612) 462-0420

HEALTH QUESTIONNAIRE

Name ____________________

Birthdate ____________ Age ________ Sex ____ M ____ F

Marital Status ____ M ____ S ____ D ____ W No. of Children ________

Address ____________________

City ____________ State ________ Zip ________

Home Phone ____________ Email ____________

Occupation ____________ Work Phone ____________

Physician ____________ Clinic ____________

Address ____________ Phone ____________

In case of emergency notify ____________ Phone ____________

Who referred you? ____________________

Have you had acupuncture before? ____

Name and address of past acupuncturist ____________________

List the main health concerns you would like us to help you with ____________

____

____

____

List any other health problems you have now ____________

____

____

____

List any allergies, food sensitivities, and environmental difficulties that you have ________

____

____

____

Circle any significant illnesses you have had (please include date)

Cancer ________ Diabetes ________ Hepatitis ________ Heart Disease ________

High Blood Pressure ________ Rheumatic Fever ________ Seizures ________

Other ____________________

____

HOLLE HEALTH CENTER

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List any accidents, surgeries, or hospitalizations you have had (please include date) ______________

List major diseases or health problems in your family (please include relationship) ______________

List any medications and supplements you are presently taking

Medicine	Reason	Dosage	Medicine	Reason	Dosage

Other ______________

How many cigarettes do you smoke? ______________ Packs per day / week

How much coffee do you drink? ______________ Cups per day / week

How much alcohol do you drink? ______________ Drinks per day / week

Please describe any drugs you use for non-medical purposes

Please describe your exercise program ______________

Do you currently follow a special dietary regimen? *(i.e. vegan, macrobiotic, salt-free, high-fiber, etc.)*

How do you feel about the following aspects of your life? *(Please check one box for each aspect and indicate any stress you currently have in that area)*

	Great	Good	OK	Poor	Bad	Other	Description of stress
Family							
Love							
Sex							
Self							
Work							