HEALTH OFFERINGS, INC.

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NAME: ____ DATE: ____________________

REASON FOR YOUR VISIT TODAY: ____
____
____

HAVE YOU HAD THIS CONDITION PRIOR? ☐ Yes; ☐ No
If yes, when? ____

HOW LONG HAVE YOU HAD THIS CONDITION? _________________________________

IS IT GETTING WORSE? ☐ Yes; ☐ No; ☐ Unsure

DOES IT BOTHER YOUR SLEEP? ☐ Yes; ☐ No; ☐ Sometimes

DOES IT AFFECT YOUR MOBILITY? ☐ Yes; ☐ No; ☐ Sometimes

WHAT SEEMED TO BE THE INITIAL CAUSE? ____________________________________
____

WHAT SEEMS TO IMPROVE IT? ____
____

WHAT SEEMS TO AGGRAVATE IT? ____
____

HAVE YOU HAD ACUPUNCTURE BEFORE? ☐ Yes; ☐ No

HAVE YOU USED HERBAL MEDICINE BEFORE? ☐ Yes; ☐ No

HAVE YOU SEEN A DOCTOR FOR THIS CONDITION? ☐ Yes; ☐ No
If yes, name of doctor or medical group: ____

HAVE YOU HAD AN X-RAY OR MRI? ☐ Yes; ☐ No; If yes, when? ____________________

ARE YOU IN PAIN TODAY? ☐ Yes; ☐ No
If yes, range of pain (1 = minimal, and 10 = unbearable): _____________

ARE YOU USING CONCURRENT THERAPIES? ☐ Yes; ☐ No
If yes, please list: ____
____
____
____
____