Harris Gibson
Board Certified Acupuncturist
856.649.9896

Medical History

Birth: Anything significant about your birth: _____

_____

Vaccination History: Any reaction that you remember? Any unusual vaccination?_____

_____

Childhood Illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age:_____

_____

____age:_____

_____

____age:_____

_____

Adolescence Illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age:_____

_____

____age:_____

_____

____age:_____

_____

Adulthood: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age:_____

_____

____age:_____

_____

____age:_____

_____

Family History: please note all major illnesses in your close family such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.

_____

_____

_____

_____

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Note: information provided on this form is confidential. Today's Date: ___/___/___

Name:_____.Age:_____ Sex: Male Female

Address_____Occupation_____

City_____State Zip_____Date of birth ___/___/___Telephone:

Day_____Ext. Evening:_____e-mail_____

How did you hear about us?_____

Under a physician's care? Name & phone of physician:_____

What would you like treated by Acupuncture?_____

How long have you had this condition?_____Was onset sudden gradual

Symptoms are worse by_____ Symptoms better by _____

What medical diagnosis have you received?_____

What other treatments have you received for this and/or other conditions?_____

_____

How has this condition changed your life?_____

_____

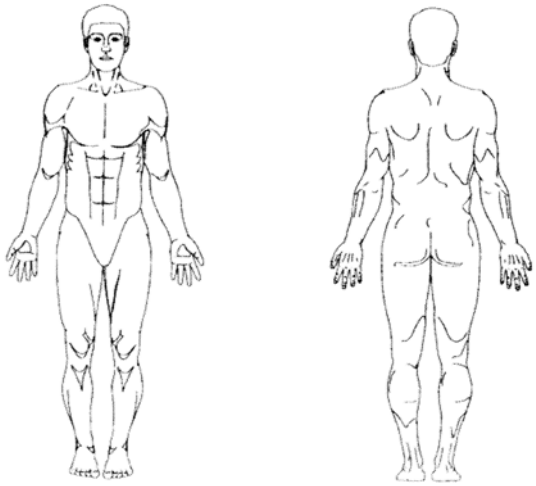
Are you taking any medication? Please note all medication, herbs, vitamins and minerals you take even if you take them only occasionally._____

_____

Are you currently pregnant? Yes No

Are you presently trying to get pregnant? Yes No

On the following drawing shade the areas you feel should be addressed.



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Underline current conditions. Put a check mark in the box for former conditions. Add any additional information regarding duration, frequency, intensity and pain regarding current symptoms.

Have you had any of these?

☐ AIDS/HIV	☐ Cancer	☐ Lyme Disease	☐ Seizures
☐ Alcoholism	☐ Diabetes	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Allergies	☐ Emphysema	☐ Pacemaker	☐ Polio
☐ Asthma	☐ Heart Disease	☐ Lymph nodes removed	☐ Rheumatic Fever
☐ Hepatitis A/B/C	☐ Scarlet Fever	☐ Headache	☐ Birth Trauma
☐ Herpes	☐ Other_____		(your own birth)