Mountain Therapeutic
Massage and Acupuncture Clinic
Bryson City, North Carolina

HEALTH HISTORY QUESTIONNAIRE

Name:	DOB:	Ht/Wt:	Age:

Address:

Email: ☐ Check here to receive our email newsletter

Phone #: Cell:

Occupation: Marital status:

Emergency Contact Name: Phone:

Who may we thank for referring you?

Recent Health Care Providers: Name, Date, Service Provided:

MAIN CONCERN:

How does this problem affect your daily activities?

When did you first notice symptoms?

If you have been diagnosed, what is diagnosis?

What kinds of treatment or therapies have you tried?

Hospitalizations/Surgeries/Accidents:

Allergies:

Family Health History

Family Member	*Age*	*Important Diseases/Illnesses*	*Deceased Y/N*