Root Healing Acupuncture

Patient's Name ____ Date __________

How did you hear about us? ____

Have you ever received acupuncture or functional medicine before? (circle) Yes No

MAIN COMPLAINTS (list in order of importance):

1) _________________________________ 2) _________________________________

3) _________________________________ 4) _________________________________

If you have a pain condition, on a scale of 1 to 10, what is it at its worst? _______

How long have you suffered with this problem?

____

Do you know how this problem may have started? (i.e. earlier accidents, injuries, physical stresses, fall, repetitive motion on the job etc.)

____

What have you tried doing to resolve this problem that DID NOT work?

____

____

How does your condition affect your life?

____

____

Where do you picture yourself being in the next 3-5years if this problem is not taken care of? Please be specific.

____

____

On scale of 1-10, what is your commitment to resolving your condition? _____

Do you have any concerns? (i.e. Time, Transportations, Finances, etc.)

____