



# Susquehanna Acupuncture & Healing Arts Center

# Medical History

CONFIDENTIAL

The Susquehanna Acupuncture & Healing Arts Center □ 44 W. Market Street □ Marietta, PA 17547  
 www.SusquehannaAcupuncture.com

Phone: 1-717-429-3166

NAME (LAST, FIRST, MIDDLE)	DATE
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MAJOR COMPLAINT / HEALTH PROBLEM

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HOW DID THIS CONDITION DEVELOP?

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HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?
WHAT WERE THE RESULTS OF THE TREATMENT?	

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD:	
DATE	PROBLEM / SURGERY
_____	_____
_____	_____
_____	_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

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SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	