WHIDBEY
ACUPUNCTURE
+ HERBS

CONSULT FORM
(CONFIDENTIAL)

Name: Age: Date:

	Severity									
Main Complaint:	1	2	3	4	5	6	7	8	9	10
Additional Complaint:	1	2	3	4	5	6	7	8	9	10
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How long has the Main Complaint been an issue?

Is the severity constant or variable?

How do these health challenges
affect your life?

Have you had to give up anything
you love because of this?

How are you feeling about this?

☐ Worried	☐ Depressed	☐ Frustrated
☐ Angry	☐ Overwhelmed	☐ Afraid
☐ Lonely	☐ Exhausted	☐ Anxious

How motivated are you to resolve this?

What have you tried so far?

Are you willing to modify your diet to get better?

Are you willing to adopt new habits?

Do you have any major medical procedures
or changes in medications coming up?