



*Carol Burke, CRNP, MAC, LAC*  
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Confidential Health Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Today's Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_ Cell: \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

**Present Health Concerns:**

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit today? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





