



## METABOLIC ACUPUNCTURE HEALTH HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Are you pregnant or planning on getting pregnant? Yes No

Have you had any cosmetic procedures on your abdomen before? No / Yes (please list below)

\_\_\_\_\_

How happy are you with your abdomen? Rate from 1-10 with 10 being the best: \_\_\_\_\_

What part of your abdomen do you LIKE the most?

\_\_\_\_\_

\_\_\_\_\_

What part of your abdomen do you DISLIKE the most?

\_\_\_\_\_

\_\_\_\_\_

What are your goals with metabolic acupuncture?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you on a special diet?

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Gluten free                  | <input type="checkbox"/> Low carb        | <input type="checkbox"/> Vegetarian   |
| <input type="checkbox"/> Dairy free                   | <input type="checkbox"/> Low salt        | <input type="checkbox"/> Vegan        |
| <input type="checkbox"/> Nut free (Allergy? Yes / No) | <input type="checkbox"/> Low cholesterol | <input type="checkbox"/> Other: _____ |

How healthy is your overall diet and nutrition?      Excellent      Good      Fine      Bad      Terrible

Describe typical meals for you:

<input type="checkbox"/> Breakfast:	_____
<input type="checkbox"/> Lunch:	_____
<input type="checkbox"/> Dinner:	_____
<input type="checkbox"/> Snacks:	_____

How often do you exercise? \_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_

Have you lost weight in the past?      No      Yes (how much? \_\_\_\_\_ pounds, how? \_\_\_\_\_)

Do you want to lose weight in the future?      No      Yes (how much? \_\_\_\_\_ pounds)

If you want to lose weight, how committed are you?      Actively trying      Trying to get motivated      Just hoping