

WELCOME TO OUR OFFICE

Thank you for choosing our office! In order to serve you properly we will need the following information (PLEASE PRINT). All information will be strictly confidential.

Patient's name _____ Male Female
 Birth date: / / Marital status: married single divorced widowed
 Residence address _____
 City _____ State _____ Zip _____ Email _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 If patient is a child, parent or guardian's name _____
 Emergency Contact _____ Relationship _____ Phone _____
 Employment Status: Full Time Part Time Retired Other _____
 Occupation _____ Employer _____
 Physician's Name _____ Phone _____
 Last seen _____ How did you hear about us _____

INITIAL HEALTH HISTORY

What health issue do you want treated? Please describe as fully as possible.

What treatment have you been using for relief of this issue?

Have you ever had an acupuncture treatment? When and for what reason?

Are you presently being treated for any medical condition? Please describe.

Please list any medication, herbal remedy, vitamins, or other nutritional supplement you are taking.

Please read carefully and circle any illnesses you have ever had:

Allergies, Asthma, Anemia, Diabetes, Arthritis, High Blood Pressure, Insomnia, Depression, Anxiety, Migraine, Digestive Disorder, Heart disorder, Kidney disorder, Liver disorder, Cancer, Prolonged bleeding, AIDS/ARC, TB, Hepatitis, Syphilis, Warts, Herpes. (Woman) Menopausal symptoms, Menstrual disorders,

Do you have any other health concern?

Have you ever been hospitalized for any serious medical illness or operation?

_____ Date _____

_____ Date _____

Are you carrying a pacemaker? Yes_ No_ (Woman) Are you pregnant? Yes_ Week__ No_

Patient's Signature _____ Date _____