Acupuncture

Name_____ Home Phone_____

Address_____ Apt #____ Cell Phone_____

City_____ State___ Zip_____ E-mail_____

Birth date_____ Age_____ SS#_____

Occupation_____ Employer_____

Marital Status: M W D S Spouse Name_____ No. of Children_____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name_____

Circle One → **Telephone Call** **Yellow Pages** **Sign** **Website** **Presentation** **E-mail** **TV** **Newspaper**

2. Reason for visit today: _____

3. Other problems: _____

4. How long have you had this condition?_____ Have you ever experienced this before **YES** **NO**

5. What seemed to cause the problem?_____

6. What seems to make it better?_____ What seems to make it worse?_____

7. When does it bother you? _____

Medicines?

Prescription drugs you are currently taking:

_____

_____

_____

Over-the-counter medications:

_____

_____

_____

Have you ever been treated with acupuncture &/or Chinese herbal medicine before? **YES** **NO**

History: Place an 'X' if you have any of the illnesses below

Diabetes		Drug abuse	
Blood or bleeding disorder		Depression	
Seizures		Hepatitis	
High blood pressure		Kidney disorder	
Allergies		Thyroid disorder	
Stroke		Cancer or tumors	

The above information is true and accurate to the best of my knowledge.

Patient Signature_____ Date:_____