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This form is completely confidential. This information cannot be given to anyone outside of this office without your written permission. Thank you for answering all questions completely.

Name: ____

D.O.B._____/_____/______ Age: ______ Gender: M   F

Height:____'____" Weight:______

Address: ____

City: _________________   State:_________________   Zip code: ______________________

Would you like to be included in our mailing list? Y N

E-mail Address: ____

Would you like to be included in our e-mail list? Y N

Home #: (____)-_____ -_____ Work #: (____)-_____- _____ Cell #: (____)-_____-_____

Best # and time to reach you: Home/ Work/ Cell   Time:_________________

Appointment reminder preference: __ Telephone call/voicemail __ Text message__No reminder

Are you: Single/ Married/ Divorced/ Widowed/ Separated/ Partnership

You live with: Spouse/ Child(ren)/ Pets/ Partner/ Friend(s)/Parent(s)/ Alone

What is your occupation? ____

Hours per week:____Retired? Y/N Employer: ____

How did you hear about our clinic? ____

Emergency contact information:

Name: ___________Relationship to patient: __________Phone: (___)-____-____

Address:

____

Medical History

Have you ever had acupuncture? Y N

What are your 3 most bothersome complaints?

1.____For how long? _________________

2.____For how long? _________________

3.____For how long? _________________

What major illnesses, injuries, and/or surgeries have you had? When?_______________________

____

____

What has been diagnosed? (By M.D.) ____

____

____

Please note all major illnesses in your family; for example; diabetes, heart disease, high/ low blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.:____

____

Please list any allergies (medications, seasonal, environmental, food)___________________________

____

____

____

Please mark areas on the body with pain (P), Numbness (N), or tingling (T):

Average pain intensity:

Last 24 hours: (please circle)

Pain: 0 1 3 4 5 6 7 8 9 10

Past week: 0 1 2 3 4 5 6 7 8 9 10

How much have your symptoms interfered with your usual daily activities?

Not at all____ a little____ moderately____

Quite a bit____ extremely_____

What medications, supplements, and/or herbs are you taking?

Name	Purpose	How Long	Dosage	Last Dose