Oona S. Hull L.Ac, C.M.T., M.S.
Marisa Mijares, LA.c
Gina Renee, LA.c
Acupuncture  Chinese Medicine  Massage
26350 Carmel Rancho Lane. Suite 200 Carmel CA 93923
(831) 624-3076 Fax (831) 626-3931

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.:_____

_____

_____

_____

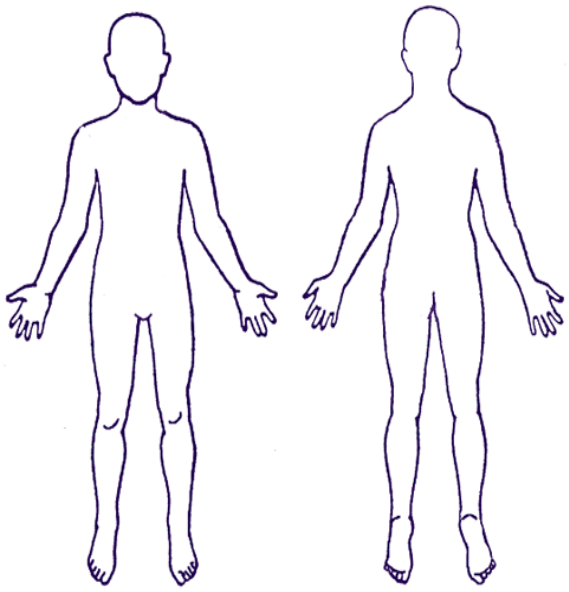
**Please list any allergies (medications, seasonal, environmental, food)**_____

_____

_____

_____

**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 2 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 |
|---|---|---|---|---|
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