

PLEASE PRINT

Name _____ Date ____/____/____

Address _____ City _____ State ____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Which number is your main contact number _____ Email address _____

Age _____ Date of birth ____/____/____ Male /Female _____ Height _____ Weight _____

Occupation _____ Employer _____ Health Insurance _____

Please list the Main Health Problems you would like to address, in order of importance:

1) _____ When did this condition begin _____

2) _____ When did this condition begin _____

3) _____ When did this condition begin _____

What makes these conditions better or worse, and how do they impair your daily activity?

Health Practitioners seen for these conditions: _____

Any previous diagnosis? _____

Treatment protocol? _____

Are you currently on any medications or supplements? ____ Please list, along with dosage:

Have you had Acupuncture before? _____ Herbal Medicine? _____ When? _____

Are you allergic to any medication? (please specify) _____

Contact in case of emergency: Name _____

Number _____ Relationship to you _____