Patient Information

Last Name: _____ First Name: _____ Gender: _____

Preferred Name: _____ Birth Date: _____ Age: _____

Marital Status: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____

Email: _____ Referred by: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Primary Physician Name: _____ Phone: _____

Medical Information

Reason for visit today: _____

Additional reason for visit: _____

_____

Medical Exam/Test Finding: _____

_____

Tried any other treatment? _____

Sleep quality: _____ Energy level: _____ Stress level: _____

Bowel movement: _____ Urine condition: _____

Allergies: _____

Past Serious Medical History: _____

_____

_____

Current Medication/Herb/Supplement: _____

_____

_____

Do you have a heart pacemaker or other devices? _____

Have you been treated with Acupuncture before? _____

_____ _____ _____

Patient name Patient/Guardian signature Date

Female Patients Only

Menses started age: _____ Length of menses: _____ Length of cycle: _____

Date of last menses began: _____

Bleeding: heavy____ medium____ light____ Blood color: pale ____red ____dark ____

Clotting: none ____ little____ lots____ Period pain: none ____ mild ____ severe____

Currently pregnant? _____ If yes, how many weeks? _____ # of children: _____

How is your discharge? _____ Age at menopause (if applicable): _____

Addition information: _____

_____

_____

_____ _____ _____

Patient name Patient/Guardian signature Date