Patient Information

Name: _____
Last First Middle

Address: _____
Street City State Zip

Birth Day ____/____/____ Marital Status _____ Sex _____
M D Y

Tel (H): _____ Occupation _____

Tel (O): _____ E-mail: _____

Tel (C): _____ Insurance Name: _____

Insured's Name: _____ Tel: _____

Insured's Birth Day: _____ Policy No. _____

What Is your main problem ? _____

_____

_____

Did you try acupuncture treatment before ? ☐ Yes ☐ No

Do you have/or had any of the following:

Cancer	☐Yes	☐No	Allergies	☐Yes	☐No
Diabetes	☐Yes	☐No	AIDS	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Previous Surgery	☐Yes	☐No
Heart Disease	☐Yes	☐No	Smoke	☐Yes	☐No

Do you have other medical Problem ?

_____

_____

_____

What medication do you take ?

_____

_____

_____

Referred by: Google ☐ Insurance Company ☐ Phone Book ☐ Other ☐: _____

Patient's signature _____ Date _____