Patient Information

Name: _____
Last First Middle

Address: _____
Street City State Zip

S. S. No. ___ – ___ – ____ Birth Day ___/___/___ (M D Y) Sex _____

Tel (H): _____ Occupation _____ Marital Status _____

Tel (O): _____ Referred by _____

Tel (C): _____ E-mail: _____

Insurance Name: _____ Tel: _____

Insured's Name: _____ 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 ?

Patient's signature _____ Date _____