Patient Information

Name: ______________________________
Last First Middle

Address: ______________________________
Street City State Zip

Birth Day ____/____/____ Marital Status __________ Sex ______
M D Y

Tel (C): ______________ Occupation ______________

Tel (H): ______________ E-mail: ______________

Tel (O): ______________ Insurance Name: ______________

Insured's Name: ______________ Tel: ______________

Insured's Birth Day: ______________ Policy No. ______________

What Is your main problem ? ______________________________

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Did you try acupuncture treatment before ? ☐ Yes ☐ No

Do you have/or had any of the following:

Cancer	☐Yes	☐No	Vaccinated/Covid-19	☐Yes	☐No
Diabetes	☐Yes	☐No	Fever	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Short of Breath	☐Yes	☐No
Heart Disease	☐Yes	☐No	Cough	☐Yes	☐No

Do you have other medical Problem ?

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What medication do you take ?

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Referred by: Google ☐ , Insurance Company ☐, Yelp ☐, Facebook ☐, Other: ______________

Patient's signature ______________ Date ______________