PLEASE FILL IN ALL THE FOLLOWING INFORMATION AS COMPLETELY AS POSSIBLE

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE OR ALLOCATED STORAGE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED TO DO SO.

NAME _____ **DATE** _____

ADDRESS _____

CITY, STATE & ZIP CODE _____

HOME PHONE _____ **CELL PHONE** _____

BIRTHDATE _____ **AGE** _____ **WEIGHT** _____ **MARITAL STATUS** _____

EMERGENCY CONTACT _____

CONTACT PHONE NUMBER _____

EMAIL ADDRESS _____

HOW DID YOU HEAR ABOUT US? (NAME IF APPLIES) _____

HAVE YOU EVER HAD ACUPUNCTURE BEFORE? IF SO, WHAT FOR? _____

_____

HAVE YOU HAD AN ACCIDENT IN THE LAST 2 YEARS? _____

DO YOU HAVE, OF HAVE YOU EVER HAD, HEPATITIS? IF YES, WHEN & TYPE? _____

_____

DO YOU HAVE AIDS OR HIV VIRUS? IF YES, HOW LONG? _____

HAVE YOU EVER HAD HEART PROBLEMS OR SYMPTOMS? _____

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR? _____

DO YOU HAVE ANY KIND OF ELECTRICAL OR ANY IMPLANTS? IF SO, WHAT? _____

_____

*****IF YOU HAVE A PACEMAKER, DEFIBRILLATOR, OR CERTAIN ELECTRICAL IMPLANTS WE CAN NOT DO ACUPUNCTURE BUT OFFER ALTERNATIVES*****

ARE YOU PREGNANT? _____ **IF YES, HOW LONG?** _____

WHAT IS REASON FOR YOUR VISIT TODAY? _____

_____

CURRENT MEDICATION? _____

_____

SURGICAL HISTORY _____

_____

*****WE DO NOT ACCEPT INSURANCE. WE ACCEPT PAYMENTS IN THE FORM OF CASH, CHECK, VISA, MASTERCARD OR DISCOVER.*****