Acupuncture & China Medical

INITIAL CONSULTATION & PATIENT INFORMATION

All of your answers will be held **absolutely** confidential. If there is anything you wish to bring our attention which is not asked on this form, please note it in the Comments section. Thank you.

Name_____ Phone_____ Email_____

Address _____ City_____ State_____ Zip_____

Age_____ Date of Birth_____ Occupation_____ Marital Status_____

Emergency Contact Person_____ Phone _____

Your Primary Dr's Name_____ Phone _____

Insurance Company _____ I.D. #_____

Referred by_____ Or Yelp_____ Website_____ Facebook_____ Other_____

Have you been treated by Acupuncture or Oriental Medicine before? _____

Main Problem(s) you would like us to help you with _____

_____

How long ago did this problem begin (be specific)? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?_____

Is this problem work related?_____ Or cause by Auto Accident?_____

Have you been given a diagnosis for this problem? If so, what? _____

What kind of treatment have you tried? _____

Are you taking any medication? _____ Name of medication_____

Do you have any allergies to drugs, herbs, or foods?_____ If yes what? _____

Your Health Condition: Do you have/had?
Arthritis / Asthma / Aids / Alcohol addiction / Allergies / Anemia / Back pain / Bronchitis / Bleeding disorder / Caner / Candida / Chest pain / Colon disease / Depression / Drug addiction / Diabetes / Dizziness / Fatigue / Gastritis / Headaches / Hepatitis / Heart disease / High blood pressure / Insomnia / Joint pain /Kidney disease/ Major surgery / Seizures / Stroke / Thyroid disease or ? _____

Women Only: Are you pregnant? _____ Date of last menstruation_____
PMS_____ Menopause_____ Or? _____

Comments: _____