Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone_____Email_____Work Phone_____

Occupation _____ Person Responsible for your account _____

Emergency Contact: Name_____ Phone_____

Who should we thank for referring you to this office?_____

Sex: ❑ Male ❑ Female Height_____ Weight _____ Birthdate _____ Age _____

Marital Status: Married Single Divorced Widowed Number of children _____

Have you received acupuncture therapy before? ❑ Yes ❑ No

When? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	❑	❑	_____	Diabetes	❑	❑	_____
Hepatitis	❑	❑	_____	Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____	Seizures	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Emotional Disorders	❑	❑	_____
Infectious Diseases	❑	❑	_____	Tuberculosis	❑	❑	_____

Sexually Transmitted Diseases: ❑ Gonorrhea ❑ Syphilis ❑ AIDS ❑ HPV ❑ Chlamydia ❑ Herpes Date _____

List any medications and supplements your are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Check the Box if any of the following statements are true:

❑ I have known allergies ❑ I am taking Coumadin/warfarin

❑ I have a pacemaker ❑ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee/black tea	❑	❑	_____	Tobacco	❑	❑	_____	Water Intake	❑	❑	_____
Non-medical drugs	❑	❑	_____	Alcohol	❑	❑	_____	Soda pop	❑	❑	_____