

PATIENT INFORMATION FORM

DATE: _____

Name: _____ Telephone: _____

Address: _____ City _____ St _____ Zip _____

Gender: _____ Age: _____ Date of Birth: _____ Height: _____ Weight: _____

E-Mail: _____ Marital Status: _____ Number of Children: _____

Occupation: _____ Emergency Contact: _____

How did you hear about us? _____

Does your insurance company cover Acupuncture? _____

A: PRIMARY COMPLAINT - (Describe your symptoms to the best of your ability):

B: SECONDARY COMPLAINT(S) - (List any other symptoms you are experiencing, whether or not it may seem related to your primary complaint). _____

When did your primary complaint first occur? _____

How long or how often has it been occurring? _____

To what extent does this problem affect your daily activities (work, sleep, eating, energy, etc.)?

When and under what circumstances does it seem to get better? worse? _____

Have you undergone any other treatment for this condition? _____

MEDICAL HISTORY: (List relevant past illnesses, injuries, surgeries with dates) _____

SIGNIFICANT FAMILY MEDICAL HISTORY: (List briefly and whom) _____

Comments:

Any other concerns you would like to discuss? _____

