MICHELLE MANTO

Berkshire Acupuncture & Wellness

Helping People Heal

PATIENT INTAKE

Name: _____ Date: _____

Please complete this information to the best of your ability. Your answers will help us determine which course of treatment will be best for you. Thank you.

Birth date:	Birth place:		Age:
Home address:		Social security #:	
Home phone:	Cell phone:	Home fax/email:	
Emergency contact:	Address:		
Home phone:	Cell phone:	Home fax/email:	
Employer:		Occupation:	
Work phone:		How long:	
When/where is the best time to reach you:			
Whom should we thank for referring you to us:			
What other family members have we seen:			
Have you ever had: Acupuncture, Herbal Medicine, Moxa, Cupping, Gua Sha, Tuina (please circle)			
Primary care physician:		Address/phone:	
Name/date last seen by a medical doctor:			
Reason for visit:		Diagnosis:	
Siblings-age and in relation to you:			
How old were your parents when you were born:			
Describe your birth:			
Child(ren)-name, age, your age at delivery, birth description:			
Hobbies, recreational interests and activities:			

Please list any major accidents, traumas, surgeries, significant illnesses and injuries:

Incident	Date	Type of treatment	Outcome

Do you wear a pacemaker?	Have heart disease?	Are you pregnant?

List any medications/supplements:	Reason for taking:	Amount taking:
Please list any allergies:	Food sensitivities:	Addictions:
What exercise do you do:	How often and for how long:	Exercise history:
Describe your breakfast and lunch:	Dinner:	Snacks:
Smoke (how much):	Alcohol (how much):	Coffee/Black Tea (how much):
Sugar/sweets (how much):	Soda (how much):	TV/computer (how much):
Alcoholism (who):	Cancer (who):	Depression (who):
Diabetes (who):	Heart disease (who):	Stroke (who):
HIV/Aids (who):	Hep C (who):	STD (who):
Reason for consulting this office:		
Specific Symptom or Problem:		
How you think acupuncture can help:		
Please describe the history and the nature of your concern:		
Other practitioners you have consulted:	Reason:	Outcome:
Any other complaints, symptoms or concerns which you feel are important that have not been covered:		
Are you interested in a maintenance health program?		

PAYMENT: I understand that I am financially responsible for all charges at time of service.

_____ _____

Patient Signature Date