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?____
____