Tell us about yourself.
(this form is confidential)

Name: _____ Sex: ____ Today's Date: _____

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

Address:

_____

_____

_____

Telephone: _____

Email: _____

☐ Please do not email me

Occupation: _____

Marital Status: _____ Number of Children: _____

Emergency Contact:_____ Phone: _____ Relation: _____

Please check all that apply:

- ☐ I am Pregnant
- ☐ Seizure Disorder
- ☐ Pacemaker
- ☐ Hemophilia
- ☐ I take a Blood Thinner
- ☐ Heart Disease
- ☐ Emotional Disorder
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Tobacco
- ☐ Alcohol
- ☐ Marijuana
- ☐ Other Drugs

Please list all medications and supplements you take:

May we discuss your case with your doctor? _____

Your Signature: _____

Doctor's Name: _____

Dr.'s Phone: _____

Dr.'s Address: _____

Do you have any:

Dietary Restrictions: _____

Food Sensitivities: _____

Allergies: _____

Large Scars: _____

Skin Abnormalities: _____

Recurring Dreams: _____

Bad Habits: _____

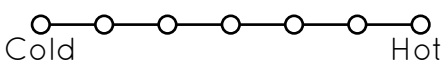
Have you had long term or intense exposure to:

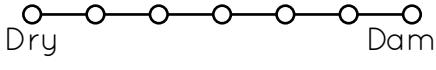
Cold Heat Wind Dryness Dampness

What kind of weather do you like?

_____

How does your body feel to you?





What is your main reason/goal for coming here? _____

Have you ever had acupuncture before? If so, when?_____

Who can we thank for referring you here? _____

What did you have for breakfast today? _____