Acupuncture & Wellness Centers

Patient Form

Name (Last) _____ (first) _____ Sex(Male/Female) Date _____

Phone (Home) _____ (Cell) _____ (Work) _____

Email Address _____ Age _____ D.O.B. _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ Physician _____

Emergency Contact _____ Emergency # _____ Referred By _____

Check (v) for Current Conditions. Circle (o) for Previous Conditions

- ☐ Headaches
- ☐ Dizziness
- ☐ Insomnia
- ☐ Nervousness
- ☐ Depression
- ☐ Allergies
- ☐ Asthma
- ☐ COPD
- ☐ Smoking
- ☐ Alcoholism
- ☐ Vertigo
- ☐ TMJ
- ☐ Arthritis
- ☐ Difficulty Breathing
- ☐ Irregular Heartbeat
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Poor Circulation
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Pregnancy
- ☐ Cancer
- ☐ Venereal Diseases
- ☐ Contagious Illness
- ☐ Vomiting
- ☐ Ulcer
- ☐ Nausea
- ☐ Fibromyalgia
- ☐ Thyroid
- ☐ Gallbladder
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon
- ☐ IBS
- ☐ Hemorrhoids

Males Only

- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Prostate

Females Only

- ☐ Hot Flashes
- ☐ Menopause Symptoms
- ☐ Congested Breast
- ☐ Extreme Cramps
- ☐ Vaginal Discharge

Major Complaint(s):

_____

_____

_____

_____

_____

How long has this been an issue?

_____

_____

_____

Causes/Medical Diagnosis:

_____

_____

_____

_____

Have you received other acupuncture treatments? If so, where and when?

_____

_____

Check any previous/current condition

- ☐ Shingles
- ☐ Hepatitis
- ☐ Pacemaker
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Breast Implants

Do you have any allergic reactions (Please list)

_____

_____

_____

List current medication(s) and supplements:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____