Merriam Park Acupuncture

Name: _____

Date Of Birth: _____Age:_____

Address:_____

City: _____ State:_____ Zip: _____

Phone Number:_____

Email Address:_____

Sex: F M T O_____ Height:_____Weight: _____

Emergency Contact Name and Phone Number:_____

Primary Physician Name and Location:_____

How did you find out about us?_____

Reason for today's visit: _____

_____

How long have you had this/these condition(s)_____

What seems to be the cause?_____

What makes it worse or better?_____

Have you seen a primary care physician for the above condition(s)? _____

Medical Diagnosis:_____

Have you received any other treatment for the above condition(s)?_____

Medications:_____

Supplements:_____

Family History of Illness(s):

Maternal:_____

Paternal:_____

Allergies:_____

Please supply details for any areas in which you have symptoms. Please mark any that do not apply as "n/a".

Merriam Park Acupuncture

Cardiovascular:_____

_____

Respiratory:_____

_____

Digestive:_____

_____

Ear, Nose, & Throat: _____

_____

Vision:_____

_____

Musculoskeletal/Joint:_____

_____

Urinary:_____

_____

Menstrual/Reproductive: _____

_____

Mental/ Emotional:_____

_____

Dermatological/ Hair:_____

_____

Energy Level:_____

_____

Medications:_____

_____