Merriam Park Acupuncture

Name: _____

Date of Birth: _____Age:_____ Marital Status: S - M - D

Address:_____

City: _____ State:_____ Zip: _____

Phone Number:_____

Email Address:_____

Sex: F - M - T - O_____ Height:_____Weight: _____

Occupation _____ Employer _____

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:_____

Allergies:_____

Family History of Illness(s):

Maternal:_____

Paternal:_____

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

Cardiovascular:_____

_____

Respiratory:_____

_____

Digestive:_____

_____

Ear, Nose, Throat, Eyes: _____

_____

Musculoskeletal/Joint/Body Pain:_____

_____

Urinary:_____

_____

Reproductive/Menstrual: _____

_____

Mental/Emotional:_____

_____

Dermatological/Hair:_____

_____

Energy Level/Changes recently:_____

_____

Is there anything else you would want your acupuncturist to know? _____

_____

Have you had acupuncture before? _____