

Acupuncture & Chinese Medical Center
(Please Print)

Name _____ Cell phone _____

Work phone _____ Home phone _____

E-mail _____

Today's date _____ Sex _____ Address _____

City _____ State _____ Zip _____ Date of birth _____

Age _____ Height _____ Weight _____ Employer _____

Occupation _____ In case of emergency contact _____

Relationship _____ His/her phone _____

Recommended by _____

Main reason for treatment, list symptoms you currently have

Diagnosis and date _____

Please circle the condition

Habits: Cigarettes Coffee Alcohol Recreational drugs Crave sugar Crave chocolate

Other _____

Family history: Arthritis Gout Asthma Cancer Diabetes

Heart Disease Strokes High Blood Pressure Kidney Disease Tuberculosis

Other _____

CONDITIONS: Please circle the condition (s) you currently have or have had in the past:

Anemia Anxiety Arthritis Asthma Bleeding Disorder Bronchitis Cancer Carpal Tunnel

Depression Diabetes Emphysema Goiter Gout Heart Disease Hepatitis Herpes

High Blood Pressure(Hypertension) High Blood Sugar High Cholesterol HIV Positive

Low Blood Pressure Low Blood Sugar Migraine Headaches Miscarriage Mononucleosis

Multiple Sclerosis On Blood Thinning Medication Prostate Problem Psychiatric Care

Seizures Stroke Thyroid Problem Other _____