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 _____

_____

Significant accidents or operations _____

_____

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_____