down to earth acupuncture

Patient Health History

Name: _____ Birthdate: _____ Age: _____ Gender: _____

Phone (home): _____ (work): _____ (cell): _____

Address: Street_____ City_____ State_____ Zip_____

Email address (may be used for scheduling & monthly newsletters): _____

Emergency Contact:_____ Phone: _____

How did you hear about our office? _____ Have you had acupuncture before? _____

Please describe your **3 main reasons** for seeking treatment, in order of importance:

1._____ Date Problem Began: _____

2._____ Date Problem Began: _____

3._____ Date Problem Began: _____

In addition to your main complaints, do you have any concerns with (please circle):

Sleep or Energy Level	Digestion or Appetite	Headaches, Joint pain, or Muscle pain
Eyes/Ears/Nose/Throat	Reproductive or Urinary systems	Lungs, Heart, or Blood
Emotions or Stress	Skin, Allergies, or Immune system	Other

For anything circled above, please specify: _____

_____

_____

_____

Please list medications (or include a separate sheet):

_____

_____

Circle all that apply:

Cancer	HIV	Hepatitis	Metal Plate/Implanted Device
Epilepsy/ Seizures	Currently Pregnant		Blood Thinning Medication/Bleeding Disorder