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 _____
_____

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: 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_____