

Acupuncture Patient Information

File No: _____

Please fill out the following section of this form. With your detailed information, a more accurate diagnosis and identification of patterns will result. This will help the doctor devise the proper treatments and schedule for you. Thank you for your cooperation!

Date: _____ / _____ / _____ (mmm/dd/yy) Birth Date: _____ / _____ / _____ (mmm/dd/yy)

First Name: _____ Last Name: _____

Place of Birth: _____ Age: _____ Sex: Male Female

Status: Married Single Widowed Divorced Separated Common Law

Phone #: Home: _____ Business: _____ Mobile: _____

Address: _____

City: _____ Postal Code: _____

Email Address: _____

Occupation (if retired, please state previous employment): _____

Family Doctor: _____ Family Doctor's #: (_____)

For Doctor's Use:

Relevant Medical History: _____

Medication being used (hyper-pressure, diabetic, cardiac – name and dosage etc.):

Medical Issues: Hepatitis Hypertension Tuberculosis Asthma Diabetes
 Kidney Problems Other allergies Heart Disease
 Allergies to medication Constipation Pregnancy Operations

Other Information: _____

Doctor' Notes: _____
