ACUPUNCTURE TREATMENT PATIENT'S INFORMATION and HISTORY

Date _____

Patient's Name Last _____ First _____

Address _____

Apt.#

_____

City State Zip code

Contact Phone Number : _____

Age _____ D.O.B. _____

Reason for your visit _____

When and how did your symptoms appear ? _____

_____

_____

Describe your symptoms _____

_____

_____

What makes it better? _____

What makes it worse? _____

What other modes of treatment/ therapy have you already received for your condition?

_____

_____

_____

Please list all surgeries, accidents, injuries, falls which occurred during childhood, adolescence and adulthood.

date _____ _____

date _____ _____

date _____ _____

date _____ _____

date _____ _____

date _____ _____