Acupuncture Evaluation Form

PLEASE PRINT   Date ______________________

Name ___________________________________   Birth date ___________________________
Address___________________________________
Cy, ST ______________________ Zip _________   Occupation ___________________________

Telephone: Home______________________   Marital Status ___________________________
Work ______________________
Cell ______________________   Referred by ___________________________

Have you ever had Acupuncture before? Y N   EMAIL: ___________________________

Main problem you would like addressed:

How long have you had this condition? ____

Onset and cause____
____

Other treatments tried:____

Physician ____________________________ Medical Diagnosis ______________________________
(List last checkup)   (if any)

Past Medical History (Please check all that apply)

__ AIDS/HIV	__ Cancer	__ Lyme Disease	__ Thyroid Disease
__ Alcoholism	__ Diabetes	__ Multiple Sclerosis	__ Tuberculosis
__ Allergies	__ Emphysema	__ Pacemaker	__ Latex Allergy
__ Asthma	__ Heart Disease	__ Polio	__Lymph Nodes Removed
__ Birth Trauma	__ Hepatitis A/B/C	__ Rheumatic Fever	
(your own)	__ Herpes	__ Scarlet Fever	__ Pnuemothorax
__ HBP	__ Seizures	__ Lung disease	

Other: ____
Surgeries: ____
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____

Are you currently taking any medications?____
Family Medical History: ____
____

Practitioner's Notes:____
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