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 (your own)	__ Hepatitis A/B/C	__ Rheumatic Fever	
	__ Herpes	__ Scarlet Fever	__ Pnuemothorax
__ HBP	__ Seizures	__ Lung disease	

Other: _____
Surgeries: _____
_____
_____
Are you currently taking any medications?_____
Family Medical History: _____
_____
Practitioner's Notes:_____
_____
_____