

ACUPUNCTURE FOR ALL

NAME _____ NICKNAME _____

ADDRESS _____
STREET APT# CITY STATE ZIP CODE

TELEPHONE _____
HOME WORK CELL

EMAIL _____

DATE OF BIRTH ___/___/___ AGE: _____ SEX: F / M MARITAL STATUS _____

OCCUPATION _____ COMPANY NAME _____

WHERE DID YOU LEARN ABOUT THE CLINIC? _____

PRIMARY CARE PHYSICIAN _____

OTHER HEALTH CARE PROVIDERS, CHIROPRACTOR, MASSAGE THERAPIST, ETC...

EMERGENCY CONTACT _____ TELEPHONE _____

REASON FOR TODAY'S VISIT _____

PRACTITIONER WILL COMPLETE THIS SECTION

AVERAGE PAIN LEVEL _____ ENERGY _____ SLEEP _____

DIGESTION _____ EMOTIONAL _____ TEMP _____

TONGUE _____ PULSE _____

DX _____ TX SCHEDULE _____

NOTES _____