WELLNESS PERSONAL HEALTH INFORMATION

Name_____ Date_____ Birthday_____

Address_____

City_____State_____Zip Code_____

Home Phone ( )_____Cell Phone ( )_____Work ( )_____

Email (Only to send you personal info on occasion)_____

Emergency Contact_____Relationship_____

What is the reason for your visit today?_____

Any other complaints?_____

Prior Treatments for the above condition_____

Please list all medications, prescribed or over the counter (including aspirin, ibuprofen, sinus meds etc.)_____

_____

Please list all vitamin and herbal supplements_____

_____

Previous History (Surgeries, Accidents, Illness) Include year and the treatment received_____

_____

Mark everything that you currently have or have had:

☐ Dizziness/Fainting	☐ Arthritis	☐ Nervousness/Stress
☐ Backache	☐ Headaches	☐ Sinus Trouble
☐ Heart Disease/Pace Maker	☐ Numbness	☐ Diabetes
☐ Asthma/Lung Issues	☐ Allergies	☐ Floaters/Vision Problems
☐ Tinnitus	☐ Migraines	☐ Neck Pain
☐ Shoulder Pain	☐ Chest Pain	☐ Digestive Disorders
☐ High Blood Pressure	☐ High Cholesterol	☐ Skin Problems
☐ Cancer	☐ Rheumatic Fever	☐ Menstrual Disorders

Anything else you would like to add:_____

_____

_____

Notes:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please note that all fees are to be paid at the time of service. If your insurance company does reimburse for acupuncture and related services, you are responsible for seeking reimbursement. Also, please give at LEAST 24 hour cancellation notice for scheduled appointments, as both your time and my time are valuable. And, please! turn off cell phones during treatment. Please sign in agreement.

Signature:_____ Date _____