The Acupuncture Studio
112 N. Person St, Suite 200

Name_____ Sex: M___ F___ Date_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Age_____ Height_____ Weight_____ Email_____

Telephone: Home_____ Work_____ Cell_____

Emergency contact: Relationship_____ Telephone_____

Single____ Married____ Divorced_____ Widowed_____ Living with_____

Occupation_____ Education_____

Referred by_____

Reason for visit today_____

How long have you had this condition?_____

What seemed to be the initial cause?_____

Date of last physical examination_____

Medicines: Prescription drugs you are currently taking: For what condition?

_____ _____

_____ _____

_____ _____

_____ _____

Over-the-counter medication you are currently taking: For what condition?

_____ _____

_____ _____

Major Hospitalizations: Write the most recent ones below (do not include normal pregnancies).

Year_____ Operation/Illness_____

Year_____ Operation/Illness_____

Year_____ Operation?Illness_____

Personal Lifestyle Habits

Cigarettes (#/day)_____ Coffee/Tea (cups/day)_____ Alcohol (drinks/week)_____

Vitamins & Herbs_____

Dietary restrictions_____ Food cravings (salty/sweet/sour)_____

Form of Exercise_____ How often?_____

Female clients only (circle one)

Irregular periods: yes/no

PMS: yes/no

Blood clots: yes/no

Are you currently pregnant? yes/no

Menopause: yes/no

Are you currently on Hormone Replacement Therapy (HRT)? yes/no