CASE HISTORY INFORMATION

Name: ______________________ Birth Date: __________ Age: ________

Sex: __________ Martial Status: __________ Social Security Number: ______________

Address: ______________________ City: ______________ State: ____ Zip: ________

Telephone (day): ______________________ (evening): ______________________

Referred by: ______________________ Email: ______________________

Your Occupation: ______________________ Employed by: ______________________

Address: ______________________ City: ______________ State: ____ Zip: ________

Your Doctor's Name: ______________________ Specialty: ______________________

Address: ______________________ City: ______________ State: ____ Zip: ________

Diagnosis by Your Doctor: ____

Present Complaints: ____

____

Please answer the following questions:

	Question	Yes / No
1.	Do you have a tendency to faint?	☐ ☐
2.	Do you bruise or discolor easily?	☐ ☐
3.	Do you bleed for a long time?	☐ ☐
4.	Do you have hepatitis?	☐ ☐
5.	Have you ever had hepatitis?	☐ ☐
6.	Do you have AIDS?	☐ ☐
7.	Do you have high blood pressure?	☐ ☐
8.	Do you have any heart problems?	☐ ☐
9.	Do you have any respiratory problems?	☐ ☐
10.	Have you been treated by acupuncture before?	☐ ☐
11.	Are taking any other therapies at the same time?	☐ ☐
12.	Any surgery before?	☐ ☐
13.	Are you taking any medications? a. Please list on other side	☐ ☐
14.	Are you hungry at the present time?	☐ ☐
15.	Are you exhausted at the present time?	☐ ☐
16.	Are you nervous at the present time?	☐ ☐
17.	(Women) Are you pregnant at the present time?	☐ ☐
18.	Do you have a compensation claim or law suit pending your complaint?	☐ ☐

Please indicate your payment method:

Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Health Insurance ☐ Worker's Compensation ☐ Personal Injury Case ☐

CONSENT FOR ACUPUNCTURE/ACUPRESSURE

I, the undersigned, realize that acupuncture/acupressure may be considered as an investigative procedure in the United States of America. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. Every attempt will be made to protect me from harm, but there may be unfavorable skin reaction, unforeseen nerve damage, possible infection, unexpected bleeding and/or other complications not anticipated. I realize that I may withdraw from the program at any time.

______________________ ______________________

Patient's Signature **Date**

______________________ ______________________

Parent or Guardian Signature (if patient is a minor) **Date**