Natural Health Renewal
Acupuncture Patient Information

Patient Name: _____ Date:_____

Age:_____ Date of Birth:_____/_____/_____ Gender:_____

Home Address:_____ Apt/Ste#:_____

City:_____ State:_____ Zip:_____

Home number: ( )_____-_____ Work/Cell Number: ( )_____-_____

Email address:_____

Occupation:_____ Employer:_____

Work Address:_____ City_____ State_____ Zip___

Emergency contact name:_____ Phone Number: ( )____-_____

Primary Physician's Name:_____ Phone Number: ( )____-_____

Referred to us by:_____

Please answer the following questions by circling Yes or No

Do you have a tendency to faint?	Yes	No	Are you HIV positive?	Yes	No
Do you have a pacemaker?	Yes	No	(Females) Are you pregnant?	Yes	No
Are you taking any blood thinning drugs?	Yes	No	Have you ever had hepatitis?	Yes	No

Current medications/drugs being taken: _____

_____

Current nutritional supplements/herbal remedies being taken:_____

_____

24 Hour Cancellation Policy: As a courtesy to my other patients and me, please notify the office 24 hours in advance if you cannot keep your appointment. We do charge a $30 fee for acupuncture appointments missed or cancelled with less than 24 hour notice.

Yes, I have read and comply with this cancellation policy. My initials: _____

Please list your major health problem(s)

Problem #1: _____

Problem #2: _____

Problem #3 _____

How long has this problem been affecting you?

Problem #1: _____

Problem #2: _____

Problem #3 _____

How frequently does it occur?

Problem #1: _____

Problem #2: _____

Problem #3 _____

Please describe how it feels.

Problem #1: _____

Problem #2: _____

Problem #3 _____

Did an accident, injury or traumatic event occur that directly caused this problem? (car accident, sports injury, stressful life event, illness, work injury, etc.)

Problem #1: _____

Problem #2: _____

Problem #3 _____

Since this problem began, what, if anything, has helped?

Problem #1: _____

Problem #2: _____

Problem #3 _____

Is there any therapy or treatment you have tried that has made a significant difference in resolving your health problem? ◯ **Yes** ◯ **No**

If you were not suffering with this health issue, what activities or hobbies would you like to be doing?

_____

_____

_____

On a scale of 1-10, ten being the highest, how committed are you to getting rid of the problem? _____

Is there anything preventing you from taking care of this problem? ◯**Yes** ◯**No**

Time is a concern? ◯**Yes** ◯**No** Money is a concern? ◯**Yes** ◯**No**

Does your spouse have questions about you receiving treatment? ◯**Yes** ◯**No**