



**East Wing
Patient Intake Form**

Patient Information

Name _____
(First Middle Last)

Address _____
(Street Apt. #)

City, State, Zip

Email _____ Phone _____

Age _____ Date of Birth ____/____/____ Sex: M F

Who may we thank for referring you? _____

***Insurance patients**

*Marital Status: Single Married Divorced Other

*Are you the primary on your insurance plan? Yes No

* If No, Name of Primary: _____ Date of Birth ____/____/____

Emergency contact: _____ Phone Number: _____
(and Relation)

Occupation: _____

Primary Care Physician: _____

24 Hour Cancellation Policy

Please make any cancellations with a minimum of 24 hours notice. If you do not provide at least 24 hours notice, or you miss the appointment your account will be charged a \$40 missed appointment fee. Thank you for your understanding.

Signature _____ Date ____/____/____

Patient Intake Form

DETAILS OF CHIEF COMPLAINT: Please answer all questions that apply to your condition. List illnesses and/or symptoms in order of importance to you / How long you've had it / Intensity (1-3-mild 4-6 moderate 7-8 intense 9-10 severe)

- 1. _____ / _____ / _____
- 2. _____ / _____ / _____
- 3. _____ / _____ / _____

Have you received any previous treatment/s for your condition? If yes, please describe:

Medical History

Do you currently have an infectious disease? ****Circle All That Applies****

HIV Genital Herpes Hepatitis (A B C) Other: (Please describe below)

Do you have a bleeding disorder? Yes No

List any accidents, surgeries, and hospitalizations _____

List any surgical implants: _____

List any medications, supplements or herbs you are currently taking and why (if more than 3, please list on the back of the page)

Allergies _____

Do you exercise regularly? _____

Your usual diet consists of:

Have you ever received acupuncture therapy before?

If yes, when and for what condition?
