

DATE: \_\_\_\_\_

## INITIAL CONSULTATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_    Work Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_

Other Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_    Age: \_\_\_\_\_    Sex: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Main Health Complaints: \_\_\_\_\_  
\_\_\_\_\_

Other Health Complaints (even you don't think Acupuncture can help)

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

Which of the above conditions is the worst? \_\_\_\_\_

What medications are you taking for it? \_\_\_\_\_

Is an insurance claim involved?    Y    N

Do you have health insurance?    Y    N

Did the injury occur at work?    Y    N

Is the injury due to an auto accident?    Y    N

Office Use Only    CM/Acupuncturist _____
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