

HEALTH & CONTACT INFO

Date: ___/___/___

Name: _____ Please call me (nickname): _____

Mailing address: _____ City/State/Zip: _____

Best phone # to reach you : _____ Other phone #: _____

Date of birth: ___/___/___ Age: _____ Gender: _____ Occupation: _____

Email address: _____

How did you hear about us?: _____

Emergency contact (name & phone): _____

Main Concerns

Please write in your top 3 health concerns in order of importance to you.

1. _____

Started: _____ Intensity: _____

How much does this affect your daily life? _____

2. _____

Started: _____ Intensity: _____

How much does this affect your daily life? _____

3. _____

Started: _____ Intensity: _____

How much does this affect your daily life? _____

What is your goal regarding these issues?

In addition to acupuncture, what else are you doing to achieve these goals?

Please list any major medical conditions that you think affect your overall health.

General Well-Being

On a scale of 1-10, how well do you take care of your physical body? _____

On a scale of 1-10, how kind are you to yourself?

Is it easy for you to drink water? _____

What activities make you feel happy and distract you from discomfort? (Reading, moving your body, kids/grandkids, cooking, gardening etc.)

How often do you do any of these activities?

