ACUPUNCTURE CENTER OF ANDOVER

Patient Intake Form

Name: _____ **Phone:** (H) _____

(W) _____

Street: _____ (C) _____

City: _____ **State**_____ **Zip**_____

Occupation: _____

Physician: _____ **Referred by:** _____

[Circle One**]** **Gender:** M / F **Marital Status:** Single / Married / Other

Age: _____ **Height:** _____ **Weight:** _____ **D.O.B.** _____ / _____ /_____

What is your most pressing problem? **Date of Onset (or try your best to recall):** _____/_____/_____

What seems to make it better/worse?

What treatment have you had for this problem?

Please list any Medication/Supplements you are currently taking:

Any Allergies (food, seasonal, chemical, pet, heavy metals etc.)?

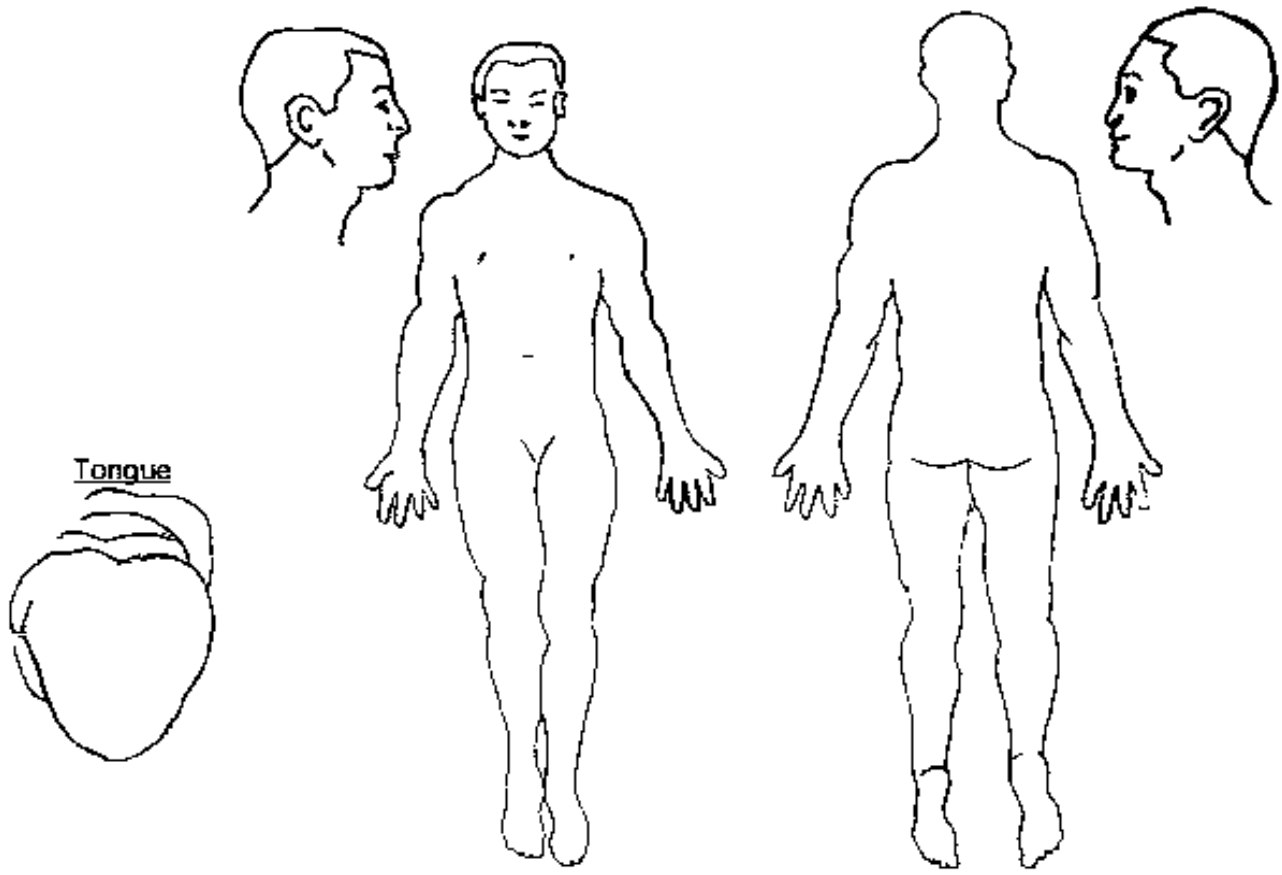
Any Digestive/Gut issues?

Any other problems?

IMPORTANT NOTE: You are responsible for any unpaid balance NOT covered by your Health Insurance Provider

Name: _____ **Date:** _____

Please shade in or [X] mark any areas of pain / discomfort you would like addressed:



ASSESSMENT:

TREATMENT:

IMPORTANT NOTE: You are responsible for any unpaid balance NOT covered by your Health Insurance Provider