HEALING SPACE
HEALTH CENTER

Personal Information

Date: ______________ Sex: ☐ M ☐ F Date of Birth: ___/___/_____

Name: ______________ Phone: ______________

Address: ______________ Zip: ______________

Email: ______________

Marital Status: ☐ Single ☐ Married/Partnership ☐ Divorced ☐ Separated ☐ Widowed

Occupation: ______________ Employer Name: ______________

Emergency Contact: ______________ Phone: ______________

Have you had acupuncture before? ☐ Yes ☐ No

Please, describe condition(s) for which treatment is sought:

1. ______________

Date of onset of symptom(s): ______________ Severity of symptoms 1-10 (1 mild / 10 severe ______

Have you seen your physician about this condition? ☐ Yes ☐ No

2. ______________

Date of onset of symptom(s): ______________ Severity of symptoms 1-10 (1 mild / 10 severe ______

Have you seen your physician about this condition? ☐ Yes ☐ No

3. ______________

Date of onset of symptom(s): ______________ Severity of symptoms 1-10 (1 mild / 10 severe ______

Have you seen your physician about this condition? ☐ Yes ☐ No

Please indicate if ANY of the following applies to you:

☐ Hemophiliac ☐ Anticoagulant use ☐ Epilepsy ☐ Diabetes
☐ Pacemaker ☐ Stroke/CVA ☐ Vegetarian/Vegan ☐ Hepatitis
☐ Heart condition ☐ HIV/AIDS ☐ Lung condition ☐ Cancer

Are you pregnant/Is there a chance that you are pregnant? ☐ Yes ☐ No

General ☐ Cold hands/feet ☐ Always feel hot ☐ Always feel cold
☐ Fever&chills ☐ Unexplained weight changes ☐ Fatigue

Please list tested or suspected allergies and related symptoms:

Foods ______________ Seasonal ______________

Drugs/Other ______________

Cardiovascular:

☐ Heart palpitations ☐ Chest pain/tightness ☐ Poor circulation
☐ Irregular heartbeat ☐ Swelling feet/ankles ☐ Varicose veins
☐ Other ______________