ACUPUNCTURE INTAKE AND TREATMENT FORM

Client please fill out sections 1 and 2

Section 1 – General info

NAME ____ Pronoun __________

STREET ADDRESS _____________________________________

CITY ________________________ PROVINCE ________ POSTAL CODE _____________

HOME/CELL# ___________________________ WORK# _____________________________

DATE OF BIRTH: M_____ D_____ Y________ Age __________

OCCUPATION ____

EMPLOYER __________________________________

EMERGENCY CONTACT: ____________________________PHONE # ____________________

FAMILY DR. _______________________________________PHONE # __________________

Chief Complaint ____

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Section 2 – Insurance info

NAME OF MEDICAL INSURANCE COMPANY:

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POLICY/PLAN NUMBER: ______________________________________

ID NUMBER : _____________________________

Section 3 – For acupuncturist

a) Onset: ____

b) Location: ____

c) Duration: ____

d) Characteristic: ____

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e) Alleviate: ____
f) Aggravate: ____

Signs and Symptoms ____
____
____
____

Tongue	Pulse

Etiology ____
Present Diagnosis ____
Treatment Principle ____

Points:
Moxa Tui Na Bleeding Gua Sha Cupping
Electrical Stimulation

Comments & Suggestions for the patient:______________________________________
____
____
____
____
____

Signature of Acupuncturist: ______________________________
Date ______________________

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