JADE CLINIC

PATIENT INFORMATION

Name_____Sex_____Birth Date_____Age_____

Address_____City_____State_____Zip_____

Cell/Home #_____Occupation/Employer_____Work #_____

Primary Physician_____Other Health Care Provider(s)_____

Emergency Contact_____Cell/Home #_____Work #_____

Referred By_____Have you used Acupuncture or Chinese Herbs before?_____

Primary Reason for Visit?

Other Complaints?

Please list any major surgeries, hospitalizations, injuries, emotional trauma:

Please list all current medications and medications used long-term in past:

Please list any supplements (e.g. vitamins, herbs) used:

Do you consider your diet to be balanced?

Please list any dietary restrictions (e.g. vegetarian, gluten-free):

Please describe your use (if at all) of alcohol, caffeine, cigarettes, and drugs:

Please list any allergies (e.g. food, drug, environmental):

Number of Pregnancies_____ Number of Births_____

Is there anything else you think is important for us to know?

*** If you need to cancel your appointment, please by sure to give at least 24 hours notice, otherwise you will be charged for the missed visit.**

Signature:_____Date_____