GROUNDED
—IN—
ACUPUNCTURE

WELLNESS & PERSONAL HEALTH INFORMATION

Name _____ Date _____ Birthday _____-_____-_____

Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____Cell Phone ( ) _____Work ( ) _____

Email (Only to send you personal info on occasion) _____

Emergency Contact ( ) _____-_____ Relationship_____

What is the reason for your visit today? _____

Any other issues?_____

Prior Treatments for the above condition_____

_____

Please list all medications, prescribed & over the counter (including aspirin, ibuprofen, sinus meds etc.)

_____

_____

_____

Please list all vitamin and herbal supplements_____

_____

Previous History (Surgeries, Accidents, Illness) Include year and the treatment received_____

_____

Mark everything that you currently have or have had in the past:

___Dizziness/Fainting	___Arthritis	___Nervousness/Stress
___Backache	___Headaches	___Sinus Trouble
___Heart Disease/Pacemaker	___Numbness	___Diabetes
___Asthma/Lung Issues	___Allergies	___Floaters/Vision Problems
___Tinnitus	___Migraines	___Neck Pain
___Shoulder Pain	___Chest Pain	___Digestive Disorders
___High Blood Pressure	___High Cholesterol	___Skin Problems
___Cancer	___Rheumatic Fever	___Menstrual Disorders

Other:_____

_____

Are you allergic to any essential oils?: _____

_____

Notes:_____

_____

_____

_____

_____

_____

By signing below you agree that all fees are to be collected at the time of service. If your insurance company does reimburse for acupuncture and related services, you are responsible for seeking reimbursement. You must give at least a 24 hour notice of cancellation for scheduled appointments, as both your time and my time are valuable. And, please turn off cell phones during treatment.

Signature:_____ Date _____