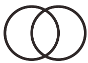

RE.BALANCE
ACUPUNCTURE

Patient Information

Name____Date________

Street Address____

City, State, Zip____

Contact Phone________________________________

E-mail______________________________________

DOB_______________ Age______ Gender__________

Ht________ Wt_______

Emergency Contact Name____

Relationship______________________ Phone________________________

Primary Care Physician Name____

Address____

Phone____________________________

OB-GYN Name (if applicable)____

Address____

Phone____________________________

Referred by______________________ Phone_________________________

Main complaint____

When did it start?____

How long have did you have this?______________________________________

Have you had this in the past? YES NO

Medications/drugs/herbs/supplements you are currently taking

____

____

____

List surgeries you have had and dates:___________________________________

____

____