Hillcrest Community Acupuncture

1807 Robinson Avenue, Suite 205, San Diego, CA. 92103 (619) 298-2228

NEW PATIENT INTAKE (**All information will be kept confidential**)

Date _____

Name_____ Age _____

Address_____

City _____ State _____ Zip _____

Email _____ Tel (____)_____

Occupation _____ How Long _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____

What is your primary health concern?

When did it start?

What makes it feel better? What makes it feel worse?

Have you had other treatment for this condition? When?

CURRENT MEDICATIONS. Include over-the-counter drugs, supplements and herbs.

Are you allergic to any medications/herbs? Y N

If yes, please list: _____

Please check if you have/had any of the following:

___Allergies___Anemia___Anxiety__Arthritis___Asthma___Bronchitis ___ Cancer

___Chronic Fatigue Syndrome___Crohn's Disease__Depression___Diabetes

___Emphysema___Epilepsy, convulsions, or seizures ___Gallstones ___GERD

___Headaches ___Heart attack/Angina___Heart failure___Hepatitis___High blood fats

(cholesterol, triglycerides)___High blood pressure (hypertension)___HIV/

AIDS___Irritable bowel___Kidney stones___Mononucleosis___Pneumonia

___Rheumatic fever ___Sinusitis ___Sleep apnea ___Stroke ___Thyroid disease

___ANY OTHER CONDITION OF IMPORT, PLEASE

DESCRIBE:_____

Please note if any apply to you:

___ Am taking Coumadin/Warfarin ___ Have a Pacemaker ___ Am Pregnant

All of this information on this form has been answered correctly to the best of my knowledge.

Signature:

Date:_____

If patient is under the age of 18 they must be accompanied by a parent or legal guardian for the entirety of the treatment. If you are a parent or legal guardian accompanying a minor, please sign below.

Signature:

Date:_____