Relief Acupuncture

700 E. Colorado St. Glendale, CA 91205
818-507-6717 Fax: 866-503-0341

Date: ___________________

Patient Last Name ______________________ First Name ___________________
Date of Birth ______________________ Sex _______ Marital Status _________________
Address _____________________________Apt: __ City __________ State ___ Zip Code _____
Tel: (   ) ____________________ E-mail ____
Occupation (Job) ____________________
Weight: __________________ Height _____________________

Emergency Contact (   ) ______________ Name: ______________ Relation ship_________

What is your main problem? ____
How long do you have this Problem? ____
Have you seen your doctor? If "yes" what is the Diagnose? _____________________________
Are you taking any Medicine, if "yes" what medication you are taking? ____________________
____
Do you have any Allergy to any Herbs, oils or Medications? ______________________________
Circle your pain level:
No pain 0 1 2 3 4 5 6 7 8 9 10 unbearable

___ Constantly ___ Frequently ___ Intermittently ___ Occasionally

Currently, how much has your pain interfered with your daily activities?

None 0 1 2 3 4 5 6 7 8 9 10 unable to carry any activity.

Please check any of following conditions that applies to you;

Abdominal Pain/ Cramp	Abnormal Menstruation	Ankle Pain	Allergy
Arthritis	Asthma	Appetite Changes	arrhythmia
Bad Breath	Belching	Blurry Vision	Blocked Nose
Breathing problem	Bronchitis	Cancer	Chest Pain
Constipation	Coughing	Cramp in muscles	depression
Diabetes	Dizziness	Dribbling Urine	Dry Skin

Patient name: DOB:

Diarrhea	Digestive issues	Eye Diseases	Eczema
Ear Ache	Fatigue	Frequent Urination	Foot pain
Gas in intestines	Gastritis	Goiter	Hernia
Hormone issues	Hearing problem	Headache	Hemorrhoids
Hepatitis	High blood Pressure	HIV/ Aids	Infertility
Indigestion	Irregular menstruation	irritability	Itching
Insomnia	Joint Pain of___	Knee pain L R	Leg Pain L R
lack of Concentration	Lack of Coordination	Low back pain	Migraine
Muscle stiffness	Night sweating		
Nausea	Numbness of __	Neck Pain/ Stiffness	Overweight
Paralysis	Poor Balance	Poor memory	PMS
Panic attack	Prostate Enlargement	Rashes	Ringing in ear
Seizures	Sinusitis	Sleepiness	Sore throat
Shoulder pain	Stomach Disease	Stroke	thoracic spine pain
Vaginal Discharge	Vertigo	Venereal disease	Tremor
Thyroid	Weakness of ---------		

Other____

Did you have any surgery in the past? _____ what and when_______________________________________
Did you have any accident in the past _____ accident Type: ___________________when ______________
Are you wearing pace maker Yes NO
Do you have contagious disease _______________________________?
Are you doing diet________ if yes Why? ____
The disease in your family ____

For Females only

Are you or might be pregnant _________if yes how many weeks____________________
Have you ever miscarried____________ if yes how many times______________

Have you had acupuncture treatment in the past? If yes what was your experience?
____

How did you find out about this clinic____?