ACUPUNCTURE CENTER OF ANDOVER

Patient Intake Form

Name: _____ **Phone:** (H) _____

(W) _____

Street: _____ (C) _____

City: _____ **State**_____ **Zip**_____

Occupation: _____

Physician: _____ **Referred by:** _____

[Circle One**]** **Gender:** M / F **Marital Status:** Single / Married / Other

Age: _____ **Height:** _____ **Weight:** _____ **D.O.B.** _____ / _____ /_____

What is Your Most Pressing Problem? **Date of Onset (**or try your best to recall**):** _____ / _____ /_____

What seems to make it feel Better / Worse?

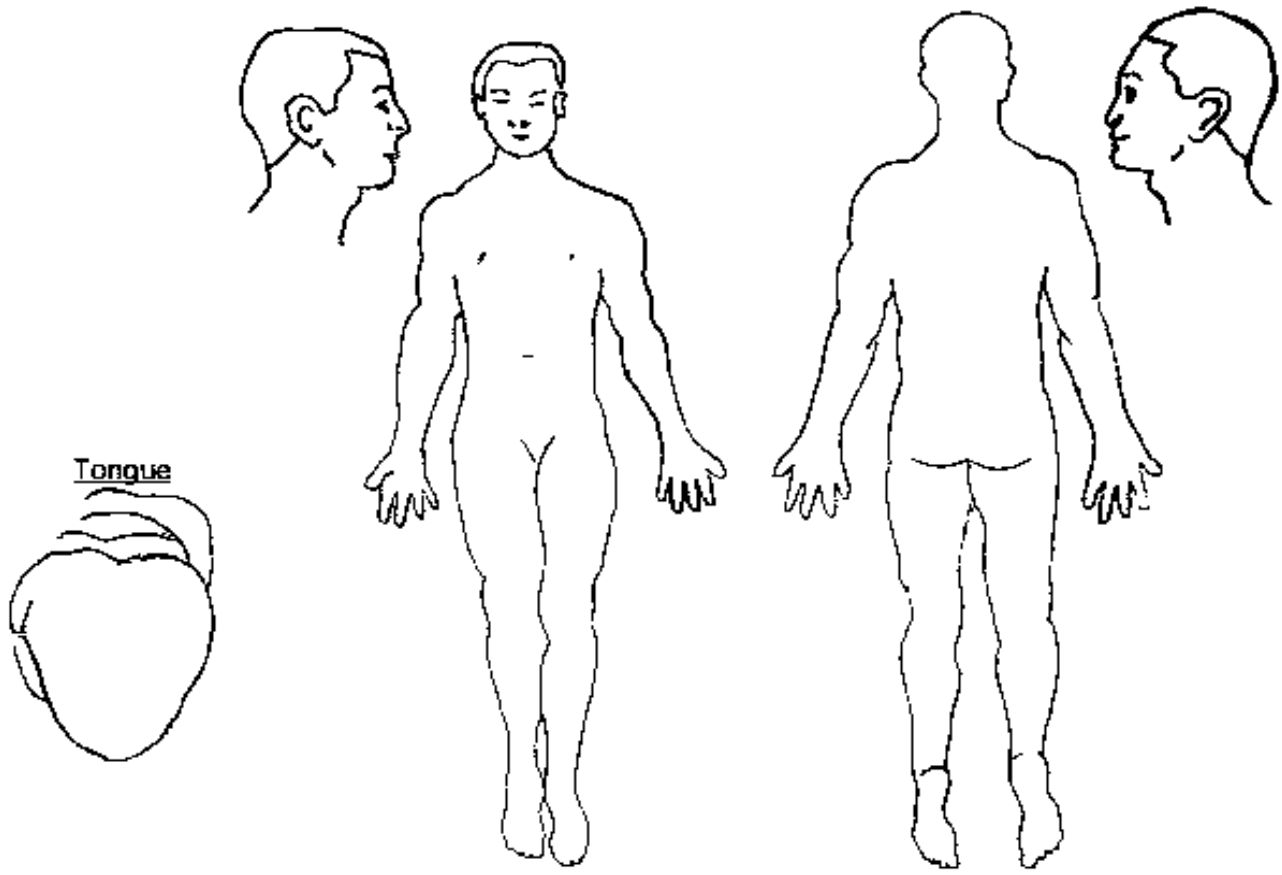
What treatment have you had for this problem?

Please list any Medication / Supplements you are currently taking:

Any other problems?

IMPORTANT NOTE: You are responsible for any unpaid balance NOT covered by your Health Insurance Provider

Please shade in or [X] mark any areas of pain / discomfort you would like addressed:



ASSESSMENT:

TREATMENT:

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