

NEW PATIENT INFORMATION

**Patient Name:**

**Date:**

**Address:**

**City:**

**State:**

**Zip Code:**

**Home Telephone: ( )**

**Work Telephone: ( )**

**Mobile Telephone: ( )**

**email address:**

**Date of Birth:**

**Age:**

**M/F**

**Occupation:**

**Marital Status S M W D**

Who/what referred you to this office?

What symptoms brought you to this office? Please list the length of time they have been bothering you.

What have you done to find relief?

Have you had tests/x-rays/scans, etc. to determine the origin of these symptoms?

\_\_\_\_\_yes \_\_\_\_\_no

Type of test(s):

Date(s):

Results:

What medicine(s) are you taking for the relief of these symptoms?

What dosage(s) are you taking?

Are you allergic to any food, medicines, herbs, etc?

Do you have any physical symptoms that are currently being treated other than the symptoms you describe above? If so, what are they?

Please list other medications and/or treatments you are undergoing that have not already been mentioned.

As you receive treatments for your present symptoms, how will you know that your problem is changing?

Have you ever had acupuncture before? If so, when?

**Thank you for answering these questions. They will help us in the understanding of your problems.**

Before your first appointment please fill out this form, print it and bring it with you  
OR  
save it (preferably your name as the document name) and email it to  
drchen@eastwesthealingcenter.net