

PATIENT HISTORY

NOTE: This is confidential record of your medical history and will be kept in Tara J. Anderson's Acupuncture Clinic. Information contained herein will not be released to any person without your authorization.

Patients Name: _____ **DOB:** _____

Address: _____

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

Phone number:(H) _____ **(C)** _____

EMAIL: _____

Occupation: _____ **Marital status:** _____

Emergency Contact: _____

How did you know about Tara J. Anderson's Acupuncture & Chinese Medical Clinic?

1. Phonebook _____ 2. Dr's. Referral _____ 3. Friend _____
4. Relative _____ 5. Brochure/Card _____ 6. Other _____

Have you had Acupuncture before? () Yes () No

Allergies: _____

Medications currently taking: _____

Supplements/Herbs currently taking: _____

Do you have any metal, defibrillator, pace maker, or any other implant? () Yes () No

If Yes, Please describe: _____