



PATIENT CONFIDENTIAL INFORMATION

Name: _____
 First Middle Last

Mailing Address: _____
 Street City State Zip

Home Phone: _____ Business Phone: _____
 Cellular Phone: _____ Email: _____

Can we leave a message? Y/N _____ At what number? Home Phone/Cell Phone _____

In case of emergency, call:
 Name: _____ Phone: _____

Date of Birth: _____ Age: _____ Gender: M/F

- I am 18 years or older. Y N
 - If 'NO' parent must sign for consent here: _____
- I understand that bleeding or bruising at needle site is a possible side effect of acupuncture. Y N
- Do you have any bleeding disorder? Y N
- Are you taking any blood thinners? (Coumadin, Heparin, Aspirin, or other) Y N
- Is your immune system compromised by cold, flu, diabetes or autoimmune disease? Y N

Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?

Do you have any infectious diseases? Y N If yes, please identify:

Please list your area(s) of facial cosmetic concern:

