Oroville Acupuncture
MEDICAL NOT MYSTICAL®

_____,_____ Male ☐ Female ☐

Last Name First Name

If not by your first name, how would you like to be called?

Date of Birth:

Address: City State Zip

Telephone:

E-mail, will only be used occasionally to send you noteworthy health news and clinic updates:

In case of emergency contact:

What is the main problem that brings you in?

How long has it been bothering you?

Was there a particular incident or accident that started this problem? If yes, please briefly explain:

Has this problem ever happened before? If yes, how long ago?

Has this problem been diagnosed by another health care professional? If yes, what was their diagnosis?

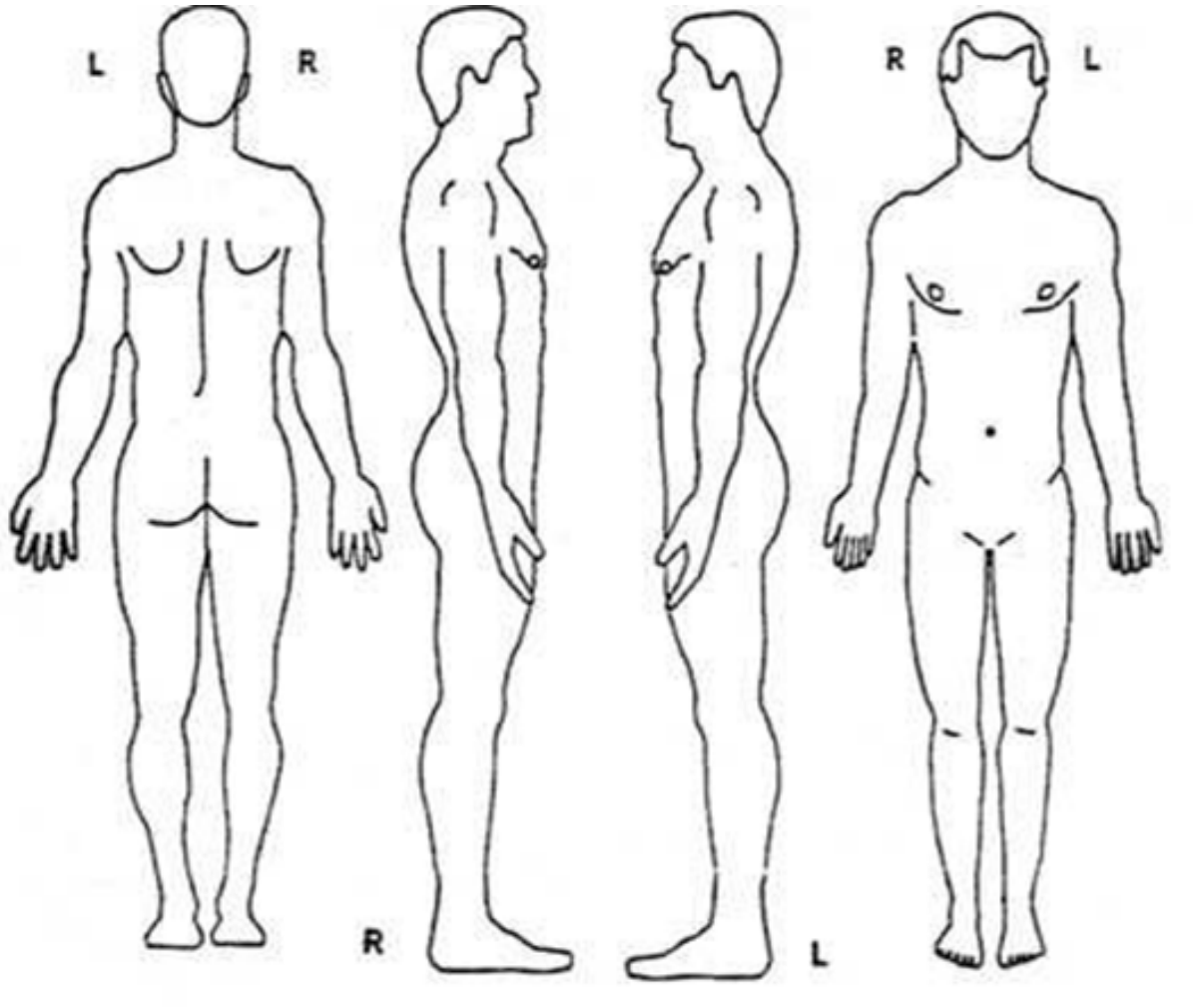
What treatments or therapies have you tried for this problem?

☐Massage	☐Ice	☐Topicals (Ben Gay, Icy Hot, Salonpas, etc.)
☐Chiropractic	☐Pain Relievers	☐Physical Therapy
☐Muscle Relaxants	☐Heat	☐Anti-inflammatories (Advil, Motrin, etc)

Have you ever had Acupuncture before?

(Please Complete Other Side)

On the picture below, please mark where your pain is. If you have numbness or tingling, please note that also.



Please list any major illnesses or surgeries you have or have had (diabetes, thyroid problems, gallbladder surgery, back surgery, etc.).

Please list all prescription medicines you are taking (if you have a prepared list we would be happy to photocopy it when you come in)

Drug name used for how often do you take it (daily, as needed, etc.)

What other health concerns do you have? (allergies, headaches, indigestion, insomnia, etc., etc.)