

# cass hicks acupuncture

## BASIC PATIENT INTAKE INFORMATION

Name \_\_\_\_\_ Phone number \_\_\_\_\_

**Primary Complaint:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Onset \_\_\_\_\_ Have you had any treatment? Yes No

If yes, when? \_\_\_\_\_ by whom? \_\_\_\_\_

Treatment type \_\_\_\_\_ Results \_\_\_\_\_

\_\_\_\_\_

Medications/herbs you are currently taking for this condition \_\_\_\_\_

\_\_\_\_\_

Have you had this condition in the past? Yes No If yes, when? \_\_\_\_\_

What makes it better? \_\_\_\_\_

\_\_\_\_\_

What makes it worse? \_\_\_\_\_

\_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other Complaints** you would like to address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE MARK YOUR AREAS OF PAIN

