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? ____

____

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____

Other Complaints you would like to address:

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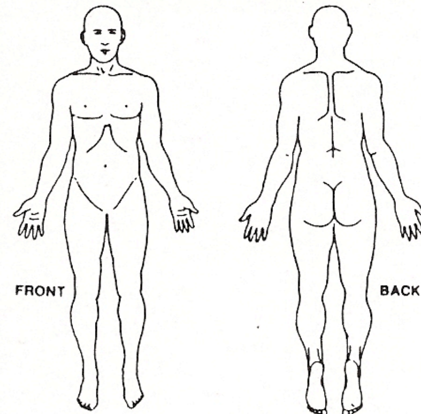

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