

Intake/Referral Form
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Acupuncture & Oriental Medicine
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 772-398-4550

TODAY'S DATE: _____

How did you hear about our office: _____

PATIENT INFORMATION

Patient Name				Social Security #:	
Address				Home Phone ()	
Apt. #		DOB: _____ Age: _____		Cell Phone () Work Phone ()	
City	State	Zip	Sex: M F	Email:	

Marital Status: M S W D	Occupation:
Weight:	Driver License Number:

Patient Contact		Contact Phone ()	
Address		Relationship to Patient	
Apt. #	City	State	Zip Code

Why are you coming to our office? _____ This is a new illness _____ This is an old illness _____ It was treated before _____ It has not been treated	Have you had Acupuncture before? Y/N	When?
	By Whom? _____	
	Last medical Examination: _____	
	Who is or was your regular doctor? _____ City _____ State _____	

If treated before, what was done?		
When?	By Whom?	Are you taking any medications? Y N
How are your dietary /nutritional habits? Good Fair Poor		Specify:

Do you exercise regularly? Y N Explain:	
Have you ever had surgery, or been hospitalized? Y N (Do not count normal births)	What was wrong?
If yes, what year?	Where?