Clinic & Spa

Lauren Berendt L.Ac.

New Patient Intake

Name_____ **Today's Date**: ____ /____ /____

Address_____**City**_____**State**_____**Zip**_____

Birthdate____ /____ /____ **Age**____ **Sex**____**E-mail**_____

Cell Phone_____ **Home Phone**_____

Occupation_____ **Employer**_____

Employer Phone_____

Primary Care Physician_____ **Phone**_____

Date of last physical exam:____ /____/ ____

EMERGENCY CONTACT INFORMATION

Name_____ **Relationship**_____

Phone_____

How did you hear about us?_____

*Acupuncture is not a substitute for conventional medical diagnosis or treatment.

*****We require full payment at the time of service. We accept cash, checks, Debit, Visa, MasterCard and Discover.

*****Kindly give us a 24 hour notice of any cancellation or reschedule need.

Please indicate if you have any of the following:

<> Hepatitis <> Pacemaker <> High Blood Pressure <>Seizure Disorder

<> HIV/AIDS <>Pregnancy <> Blood Thinning Medications <>Implanted Medical Device

Allergies to:

Drugs/Medications:_____ Foods:_____

Animals:_____ Seasonal:_____

Why are you here for acupuncture services? (health concern, well-being concern – physically, mentally or emotionally)

Please describe your medical history or conditions in the space provided:

Please list all medications, nutritional supplements, herbs or homeopathics you are currently taking:

Are there any other concerns or significant information about your health or health history that you fell you need to communicate to me?