KAISER

ACUPUNCTURE MASSAGE THERAPY

Health History Intake

Information for your Acupuncturist

General Patient Information

Name: _____ Referred By: _____

Address: _____

City, State, Zip Code: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

Age: ____ Date of Birth: _____ Gender: M __ F __ Soc. Sec. # _____

Employer: _____ City/State/Zip: _____

Spouse/Emergency Contact:

Name: _____ Phone: _____

Relationship to patient: _____

Medical History:

Primary Medical Doctor: _____ City/State: _____

Other Doctor: _____ City/State: _____

Major Complaint(s):

1. _____ 3. _____
2. _____ 4. _____

(Please initial and date the bottom right hand corner of each page)