WELLSPAN
Center for Mind/Body Health

Acupuncture Intake

Name _____ _____Date_____

Address_____City_____ State_____

Zip_____ Home Phone#_____ Work Phone #_____

Cell#_____ Date of Birth_____/_____/_____ Age_____ Marital Status_____

__Male__Female SS#_____ Occupation_____

Referred by_____ _____ Physician_____

Primary Health Problems: _____

_____

Reason for seeking Acupuncture Treatment: _____

_____

Have you had any of the following (please give dates):

Have you had acupuncture before?_____

Name of acupuncturist _____

Hepatitis_____ Herpes_____ T.B._____ HIV_____

Chronic or serious illness: _____

Severe Contagious disease: _____

Surgery: _____

Accidents or severe physical trauma: _____

_____

Psychological or emotional trauma: _____

_____

Please list all medications you are currently taking _____

_____

Please list all vitamins and/or supplements that you are taking: _____

_____

Comments or further information: _____

Name and telephone number of your doctor: _____

As a registered acupuncturist, I am required by Pennsylvania state law to have a script from a physician. An acupuncturist is responsible solely for the acupuncture evaluation and treatment. The medical diagnosis is the responsibility of the acupuncturist's supervisor. The acupuncturist will promptly consult with the supervisor regarding a new ill ness/condition, or worsened illness or condition of the patient.

Patient sign here:_____ Date: _____