Seasons of Balance Family Acupuncture, LLC
8650 US Hwy 51 N Minocqua, WI 54548

Patient Information

Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Email: _____ Phone: _____ Leave a Message: Y N

Parent/Legal Guardian if Patient is a Minor: _____

Primary Care Provider: _____ Phone: _____

Received Acupuncture before: Y N Where: _____

Reason: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Personal History

Check any illnesses or conditions you have or have had in the past:

__AIDS/HIV	__Alcoholism	__Allergies	__Asthma
__Bleeds Easily	__Cancer	__Chicken pox	__Diabetes
__Enlarged Organs(s)	__Epilepsy	__Glaucoma	__Heart disease
__Hepatitis	__High blood pressure	__High Fevers	__Jaundice
__Kidney disease	__Measles	__Meningitis	__Mental disorder
__Multiple Sclerosis	__Mumps	__Pneumonia	__Polio
__Rheumatic fever	__Shingles	__Skin conditions	__Stroke
__Thyroid disorders	__Tuberculosis	__Ulcers	__Vascular disease

__Other: _____

List allergies or sensitivities to any medications or other substances: _____

_____

Females: Are you currently or trying to get pregnant? Y N

Other

Comments (anything else you would like to tell me): _____

_____

I authorize treatment by Licensed Acupuncturists at Seasons of Balance Family Acupuncture, LLC. All information on this form is correct.

Patient (or guardian) Signature_____**Date**_____