Acupuncture Physician Care Form

NAME _____ **DOB:** _____ DATE _____
LName FName MI Mo/Day/Year

I have been diagnosed with the following condition(s) and am currently under care for these condition(s):
(Please check any that apply and provide the name and telephone number of the provider treating you)

Self	*Family*	*Diagnosis*	*Name of Treating Physician / Name of Practice & Telephone Number*
☐	☐	Hypertension (hight blood pressure)	
☐	☐	Cardiac condition	
☐	☐	Acute, severe abdominal pain	
☐	☐	Undiagnosed neurological changes	
☐	☐	Suspected bone fracture or dislocation	
☐	☐	Suspected systemic infection	
☐	☐	Serious hemorrhagic (bleeding) disorder	
☐	☐	Acute respiratory distress without previous history	
☐	☐	Pregnancy	
☐	☐	Cancer	
☐	☐	Other (specify) _____	

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Please check any that apply:

□ Diabetes	□ Seizures	□ Alcoholism	□ Kidney Disease
□ Thyroid Disease	□ Stroke	□ Lung Disease	□ Venereal Disease
□ Hepatitis	□ Asthma	□ Constipation or Diarrhea	□ Impotency
□ Rheumatic Fever	□ Allergies	□ Urinary Problems	□ Gynecological Problems
□ Arthritis	□ Mental Problems	□ HIV Positive	□ Eye Problems

GENERAL INFORMATION

Please circle the answer(s) that apply:

Appetite:	□ Good	□ Moderate	□ Poor
	□ Good	□ Moderate	□ Poor

Please list any surgeries:

_____

_____

Circle any that apply:

Cigarettes Caffeine Alcohol Drugs Salt

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality for the above conditions.

Print Name _____

Signature _____