GENTLE STRENGTH
Acupuncture

First Name:	Last Name:	Male/Female
Address:		
City:	State:	Zip:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:	Weight:	Height:
Emergency contact:	Relationship:	Phone:
Referred by:		

Please describe the main reason for your visit today:

_____

_____

Please indicate if you have any of the following:

- ☐ Cardiac pacemaker
- ☐ Seizure disorder
- ☐ Bleeding disorder/ Blood thinners
- ☐ Fainting disorders
- ☐ High blood pressure
- ☐ Believe you are or may be pregnant
- ☐ HIV/AIDS positive
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Other:_____

List all major childhood and adult illnesses:

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____