Sequim Acupuncture

502 S. Still Rd, Ste 101, Sequim, WA 98382
360-339-4050

Patient Information:

Today's Date: _____ / _____ / _____

Name: _____ Occupation: _____
Phone: Home ( ) _____ - _____ Cell ( ) _____ - _____
Address: _____ City: _____ State: ____ Zip:_____
E-mail: _____ Date of Birth: ____/____/_____

Emergency Contact: _____ Phone: ( ) _____ - _____
Relation:_____

Insurance Information:
Primary Insurance: _____ Am I the Insured? Y / N

Insured's Information (if different from patient):
Name: _____ Relationship: _____
DOB: ____/____/_____

Primary health concern:
What health issue would you like treated? _____
What makes it better? _____ Worse? _____

Patient history: *(please place a check next all that apply)*
Cancer: ____ Diabetes: ____ Hepatitis: ____ Rheumatic Fever: ____ Thyroid Disease: ____
Seizures: _____ STIs: _____ BP: High ____ Low ____
Allergies (drugs, chemicals, foods): _____
Have you ever been on a restricted diet? Yes □ No □ What Kind? _____
Do you have a regular exercise program? Yes □ No □ _____
Are you a smoker? No □ Quit □ Yes □ If yes, how many packs per day? _____
Alcohol consumption? No □ Quit □ Yes □ If yes, how many drinks per week? _____

Surgeries (type and date): _____
_____
Significant Trauma (auto accident, falls, etc.): _____
_____
Current medications: _____
_____
_____
_____

Family Medical History: *(please place a check next to all that apply)*
Cancer: ____ Diabetes: ____ Hepatitis: ____ Rheumatic Fever: ____ Thyroid Disease: ____
Seizures: _____ STDs: _____ Stroke: _____ BP: High_____ Low _____