Zen Acupuncture & Traditional Chinese Medicine

針: Acupuncture　圧: Acupressure　薬: Herbs

Name:Mr/Miss/Mrs/Ms _____(S M W D) Spouse_____
Address:_____Ph. R_____B_____
Occupation: _____M.D. _____Ph._____
Date of Birth_____Referred by:_____Email:_____

Medical History: Do you have any of the following conditions? *Check(√)*
□ Cancer □ Heart Disease □ HIV Positive □ Cold/Influenza □ Excessive Bleeding
□ High Blood Pressure □ Diabetes □ Hepatitis □ Pregnancy □ Skin Conditions_____
□ **Pregnancy(**Due date) _____□ Pain(Acute/chronic & Location)_____
Are you on medication?(If so list)_____
Accidents/Falls/Fractures:_____
Serious Illnesses/Surgeries:_____
Are you wearing a cardiac pacemaker?_____Do you smoke or drink?_____

Chief Complaint: (Location, type of pain, onset/duration, aggravating/relieving factors)

_____
_____
_____

Treatment (Past & Present):_____
Other conditions:_____

Acupuncturist's Use Only

C P A U P S E E M

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Pulse: (R)_____(L)_____Tongue:_____
Diagnosis & Treatment:_____
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_____
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