



**Christy Rollyson L.Ac.**

## New Patient Intake

**Name** \_\_\_\_\_ **Today's Date:** \_\_\_\_ / \_\_\_\_ /

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_ **Zip**

**Birthdate** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age** \_\_\_\_ **Sex** \_\_\_\_ **E-mail**

**Cell Phone** \_\_\_\_\_ **Home Phone**

**Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Employer Phone** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Date of last physical exam:** \_\_\_\_ / \_\_\_\_ /

### EMERGENCY CONTACT INFORMATION

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Phone** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

\*Acupuncture is not a substitute for conventional medical diagnosis or treatment.

\*We require full payment at the time of service. We accept cash, checks, Debit, Visa, MasterCard and Discover.



\*Kindly give us a 24 hour notice of any cancellation or reschedule need.

**Please indicate if you have any of the following:**

- Hepatitis     Pacemaker     High Blood Pressure     Seizure Disorder
- HIV/AIDS     Pregnancy     Blood Thinning Medications     Implanted Medical Device

**Allergies to:**

Drugs/Medications: \_\_\_\_\_ Foods: \_\_\_\_\_

Animals: \_\_\_\_\_ Seasonal: \_\_\_\_\_

**Why are you here for acupuncture services? (health concern, well-being concern – physically, mentally or emotionally)**

**Please describe your medical history or conditions in the space provided:**

**Please list all medications, nutritional supplements, herbs or homeopathics you are currently taking:**



**Are there any other concerns or significant information about your health or health history that you feel you need to communicate to me?**