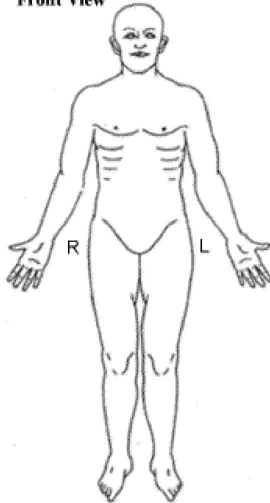
EverWell Acupuncture Center

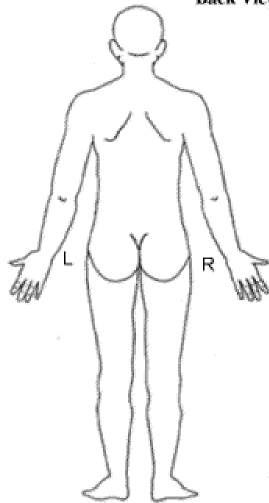
Where East Treats West Naturally

NEW PATIENT INTAKE FORM

Name: ____Date of Birth: ___________________________
Address: _____________________________________City: _______________State:____ Zip Code________
Home Phone Number: _________________________Cell Phone Number: ___________________________
CHECK IF YOU ARE: __Married __Single __Widowed __Divorced __Separated
Name of Spouse: ________________________Ages of Children: ________ Occupation ________________
How Payment will be made: ________Cash ________Credit Card _________Check
Where did you hear about us? ____

If you are in pain, please mark the exact location of your pain, as well as the frequency of your pain.
Is your pain constant, dull, sharp, on & off?





MAJOR COMPLAINT

_Neck Pain/Stiffness
_Upper back
_Mid back
_Low back
_Chest/Ribs
_Shoulder
_Arm/Elbow
_Wrists
_Hips
_Knees
_Ankles

_Headache
_Dizziness
_Fever
_Irritability
_Fatigue
_Sleeping Problem
_Stomach upset
_Ears Ring
_Nervousness
_Numbness in Fingers

What caused this condition to develop? Has this condition been remaining same or worse? ________________
____
Any falls in the past or recent that could've cased this condition? _____________________________________
____
Have you been treated for this condition? If yes, where and when and what were the results?
____
____
What causes your condition to worsen? ____
Have you had any surgeries done? ____
Are you pregnant? __ Yes __No

I (we) agree to pay for the services rendered to the above mentioned patient as the charge incurred. Fees are payable at the end time of examinations and treatment, unless other arrangements have been made in advance. X-rays remain property of this clinic. Please remember your information is confidential.

***Patient Signature: ____________________________________ Date: _____________**
Parent/Guardian Signature ____________________________ Date: _____________