

AKOYA ACUPUNCTURE

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Today's Date: _____

Name: _____ Birth Date: _____

Address: _____

Phone Number: Home Work Cell _____

E-Mail: _____ Occupation: _____

Partner Status: _____ Education: _____

Are you being monitored by a physician for any condition? Yes No

If so, for what condition? _____

Emergency Contact: _____

Contact's Phone Number: Home Work Cell _____

Do you have any allergies? (Please list) _____

Are you taking any medications? (Please list) _____

Are you taking any vitamins, supplements, herbs or minerals? (Please list) _____

If female, are you currently pregnant? Yes No

If female, are you currently *trying* to get pregnant? Yes No

Reason for seeking treatment: _____

How long have you had this condition? _____

Do you have a medical diagnosis for this condition? _____

Was it a: Sudden or Gradual onset?

What other treatments have you received for this/or other conditions? _____

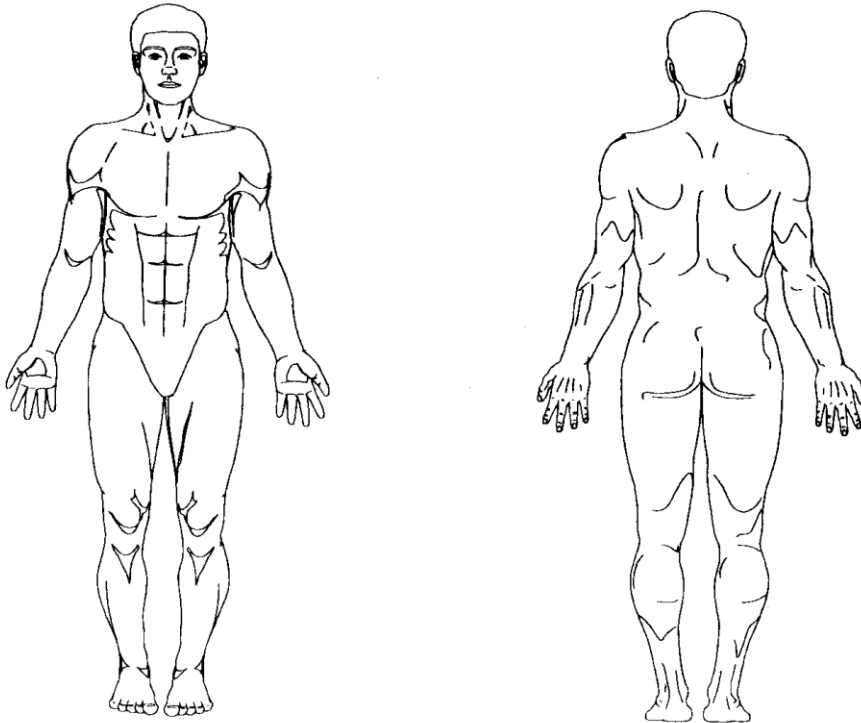
_____ Are they helpful? _____

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The pain is (check all that apply): Sharp Aching Numb Burning Dull Tingling
 Better with Heat Worse with Heat Better with Cold Worse with Cold
 Better with Massage Other _____

I have (check all that apply): Swelling Stiffness Spasms/Cramps
 Limitation of Movement Strain/Sprain Joint Clicking Muscle Weakness
 Repetitive Strain Tendonitis Bone Pain Other _____

On the diagram, please shade in the areas associated with the symptoms of your complaint(s):



Have you had or do you currently have any of the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Addiction(s) | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Hernia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Lymes's Disease | <input type="checkbox"/> Lymph Nodes Removed | |
| <input type="checkbox"/> Organ Transplant or Removal | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other _____ |