Hawthorn
NATUROPATHY • ACUPUNCTURE • MASSAGE THERAPY

ACUPUNCTURE PATIENT INTAKE

PATIENT NAME: _____

ADDRESS: _____

OCCUPATION: _____ _ AGE: _____ DATE OF BIRTH: _____

PHONE: Home_____ Cell _____ Work _____

EMAIL: _____

We request your consent to email our **seasonal featured treatments and specials** 

Please circle

MEDICAL DOCTOR: _____ OTHER PRACTITIONERS: _____

INSURANCE CO:_____POLICY #_____ ID#_____

Please any **current medications**:

_____

_____

CHIEF HEALTH CONCERNS:

_____

_____

Please indicate if the following applies to you:

Asthma	Allergies	Heart disease/Pacemaker
Diabetes	Epilepsy	Low/ High blood pressure
Blood clotting disorders	Auto-immune disease	Pregnancy

Please list any serious health concerns, illnesses or injury, including any hospitalizations with the year it occurred:

_____

_____

I understand the information I have provided on this form is confidential and will not be released without my written consent.

PATIENT SIGNATURE: _____ DATE: _____