



Katie Clifton, L.Ac.

Name: _____ Birthdate: _____ Age: _____

Address: _____

Email: _____ Phone: _____

Occupation: _____

Marital Status: S/M/D/W/Cohabiting Referred by: _____

Emergency contact name: _____ Phone: _____

Have you ever received acupuncture before? _____ If so, by whom? _____

Reason for seeking acupuncture: _____

How and when did this condition start?

Have you received previous treatment for this condition? _____

By whom? _____

What was the result/diagnosis? _____

Has the condition gotten: Better/Worse/Stayed the same

Other healthcare providers: _____

Do you have any of the following: Surgical Implants / Heart Monitor

Positive for: AIDS/HIV Hepatitis Pregnancy or suspected pregnancy

Are you fearful of needles? _____

Do you have any allergies/sensitivities to any medicines or any other substances? If so, please list: _____

Please list all the medications, vitamins, and nutritional supplements that you have taken in the past 3 months: _____

Please list any hospitalizations or surgeries:

Are you currently experiencing any family stress? Y/N

In the past year have you experienced any significant loss? (Death of a loved one or pet, job loss, miscarriage, divorce or separation, significant move, etc.)

Intuitively, what do you feel is causing your current symptoms? _

What are your expectations for your course of treatment?

How soon do you expect to get results and what is your goal?

Do you think your healing will require lifestyle changes? Y/N If so, do you believe you will be able to make them?

Please share any additional information you feel is relevant to your case: