Balingit
acupuncture

PERSONAL INFORMATION

First Name: MI: Last Name:

Birth Date: Gender: **M / F** Marital Status: Single Married Divorced Widow(er)

Home Address:

Primary Phone: ☐ Home ☐ Cell ☐ Work Alt. Phone: ☐ Home ☐ Cell ☐ Work

Email address:

Occupation:

Emergency Contact	Name: Relationship:
	Phone:

Whom may I thank for your referral?

Name/Organization/Website: ____

What is the main reason for your visit (chief complaint)?

What other symptoms bother you?

Describe any surgeries or major trauma, including incident dates:

MEDICATIONS AND SUPPLEMENTS

Please list any medications or supplements you have taken **within the past month**:

Medication(s)	**Reason for Taking**

Supplement(s)	**Reason for Taking**

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Diet

Please state any special diet you may be following (e.g. gluten-free, vegan, etc):

____

Or mark which foods you consume regularly:

☐ fruits
☐ veggies
☐ nuts
☐ whole grains
☐ refined flours

☐ fish
☐ white meat
☐ red meat
☐ processed foods (canned foods, frozen dinners)

☐ fast food
☐ junk food (chips, cookies, candy)
☐ soda
☐ energy drinks
☐ dairy

Lifestyle

Please mark any frequent habits:

☐ Caffeine Frequency: ____________________
☐ Alcohol Frequency: ____________________
☐ Tobacco Frequency: ____________________
☐ Marijuana Frequency: ____________________

Other recreational drugs:
________________________ Frequency: ____________________
________________________ Frequency: ____________________

What do you do for exercise, and how often?

____

____

On average, how many hours of sleep do you get per night? _______

Thanks! Let's begin…