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**

DIET

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

Or mark which foods you consume <u>regularly</u>:

- ☐ fruits
- ☐ veggies
- ☐ nuts
- ☐ whole grains
- ☐ refined flours/white rice
- ☐ 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…