New Patient Intake Form

Name: _____ Age: _____
Date of Birth: _____
Address: _____ City: _____ State: _____
Zip Code : _____
Phone Number: _____Email: _____
Occupation: _____
Emergency Contact: Name: _____ Relationship: _____Phone: _____
Primary Care Doctor: _____
How did you hear about Jules of Earth? _____

Reason for today's visit:

_____

_____

Is this your first experience with Acupuncture and/or Cupping? _____

Please list any prescription drugs or vitamins/ supplements you are currently taking:

_____

_____

Allergies: _____

Personal Health History --- Please check all that apply:

- ❑ ADD/ ADHD
- ❑ Alcoholism
- ❑ Arthritis
- ❑ Asthma
- ❑ Arteriosclerosis
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Constipation
- ❑ Chronic Fatigue Syndrome
- ❑ Diarrhea
- ❑ Depression
- ❑ Anxiety
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Endocrine Disorder
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High or Low Blood Pressure
- ❑ Migraines
- ❑ Vertigo
- ❑ Thyroid Disease

Other: _____

Major Surgeries (please list with approximate dates):

_____

_____

Significant Traumas (auto accidents, falls, etc. Please list with approximate date of injury):

_____

_____