REPRODUCTIVE WELLNESS
ACUPUNCTURE & INTEGRATIVE MEDICINE

Day 0
INITIAL CONSULTATION

DATE: _____ / _____ / _____

NAME: _____

ADDRESS:_____

CITY:_____STATE:_____ ZIP: _____

HOME PHONE: ( ) _____ - _____ WORK PHONE: ( ) _____-_____

CELL PHONE: ( ) _____ - _____ E-MAIL_____

EMPLOYER_____ SPOUSE EMPLOYER_____

DATE OF BIRTH: _____ / _____ / _____ AGE: _____ GENDER: _____

MAIN HEALTH COMPLAINTS:

1) _____

2) _____

3) _____

Which of the above conditions is the worst? _____

What medications are you taking for it? _____

Do you have health insurance? ☐ Y ☐ N Insurance Provider: _____

PLEASE LIST M.D.'s FIRST AND LAST NAME

PRIMARY PHYSICIAN: _____

OB/GYN: _____

RE: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

___NEWSPAPER: Which one? _____ ___LECTURE: Topic_____

___INTERNET: Search Engine_____ Ad _____

___REFERRAL: Patient _____ Doctor _____ Other _____

___HEALTH FAIR/FARMER'S MARKET (circle one): Location _____ Gift Certificate: ☐ Y ☐ N

___OTHER: _____

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