Acupuncture Treatment Center

HAN Family Acupuncture

Last Name_____ First Name _____ Initial _____

Gender _____ D.O.B._____ Marital status _____

Home phone _____ Mobile _____ Emergency number _____

E-Mail_____

Address_____ City_____

State_____ Zip_____ Can we Email You Health News **Y___ N ___**

Your occupation? _____ Number of years _____

Is your condition relay to work or type of use? _____

Self-Pay _____ Car accident _____ Workmen' Comp ___ _____

Other Health Program _____ Insurance company _____

I.D. No. _____ Group No. _____ Co-pay amount _____

What kind of surgeries have you ever undergone?

_____

What kind of illness or diseases that you have at this moment?

_____

Are you taking any other therapies at the same time, if yes please list_____?

Are you taking any medications, please list_____?

_____

(Women) **Are you pregnant at the present time** _____?

Patient Signature_____ Today's Date_____

Physician Note:

_____

Last Name	First Name	Gender	No. of Visit	Today's Date	Remarks

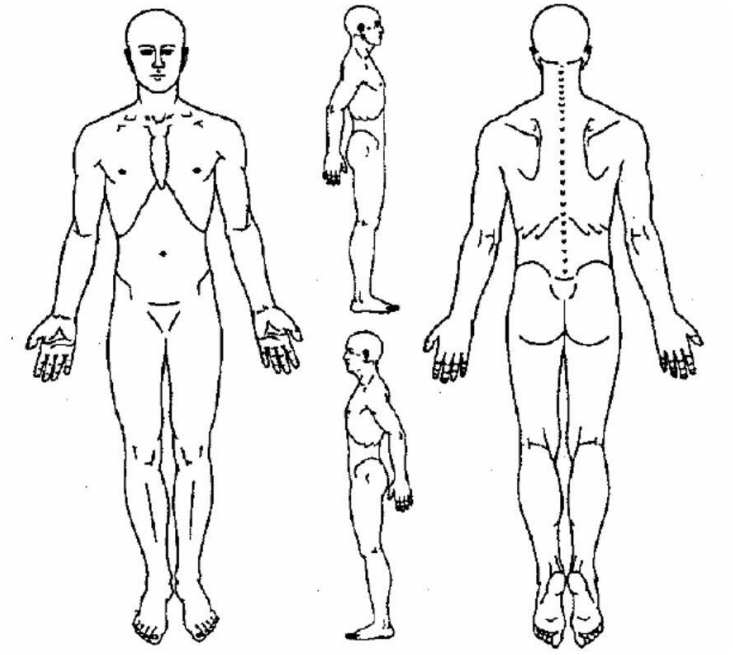
Chief Complaint:

When did the symptoms first started _____

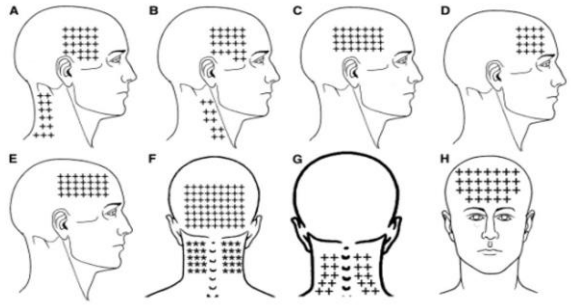
Please circle or mark the area of discomfort or injury as well as headache or migraine affecting area.
Please use the representing symbols.

Numbness	Pricking	Burning	Aching	Weakness
- - - - -	ooooo	^^^^^	xxxxx	~~~~~

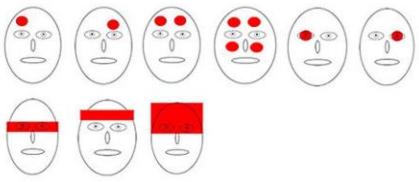
Body pain



Neck pain and headache



Migraine



Pain/numbness/weakness level before treatment on a scale 1-10

1 2 3 4 5 6 7 8 9 10

Pain/numbness/weakness level since last treatment

1 2 3 4 5 6 7 8 9 10

S.O.A.P. Note:

S:

O:

A:

P:

Recommendations:

Physician Signature: