ACU-HEALTH CENTER
CAROL RIDER, L. AC., M.T.O.M.

Name: _____
Address: _____
_____
Phone: _____
Date Of Birth: _____
Email: _____
Occupation _____
In Emergency Notify: _____ Phone_____
Have you been treated by acupuncture before? _____
If yes, reason for treatment _____
Referred by _____

Main issue(s) for which you are seeking help: _____

When did this problem begin? _____

To what extent are your daily activities affected by this problem?

What kinds of treatment have you tried?
_____

What medications are you currently taking? _____

_____

Past Medical History: (please include dates)
Cancer_____ Diabetes_____
High Blood Pressure_____ Allergies _____
Heart Disease _____ Seizures _____
Thyroid Disease _____ Other _____

Surgeries: (please include dates)_____

_____

Significant Trauma (auto accidents, falls, etc.)

_____