

# Douglas Eisenstark L.Ac.

PATIENT INFORMATION

ALL RECORDS ARE CONFIDENTIAL

NAME \_\_\_\_\_

Address \_\_\_\_\_ city \_\_\_\_\_ zip \_\_\_\_\_

Telephone \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Email \_\_\_\_\_ @ \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Occupation \_\_\_\_\_ other interests/goals \_\_\_\_\_

In case of emergency call \_\_\_\_\_

## YOUR VISIT

- What is the primary reason for your visit today? \_\_\_\_\_
- How long have you had this condition? \_\_\_\_\_
- Are you being treated for this with other modalities or western Medicine? Have you gotten a western Medicine diagnosis for this condition? (what is it?)
- Are you currently taking any medications?
- Have you had other serious illnesses or surgeries?
- How would you describe yourself in general? Are you basically happy, sad, depressed , angry scattered? (Or all the above?!)

## HISTORY

Have you been diagnosed with high blood pressure, hepatitis A/B/C, thyroid disorder, high blood pressure, anemia, HIV or any other disorders?

## ACUPUNCTURE

Have you had acupuncture before?

I HAVE CONSENTED TO HAVE ACUPUNCTURE AND HERBOLOGY AND UNDERSTAND THAT, ALTHOUGH UNCOMMON, CARRIES CERTAIN RISKS OF BRUISING AND OTHER ADVERSE REACTIONS.

Your signature is required for treatment \_\_\_\_\_ date \_\_\_\_\_