Family Acupuncture, Inc.
Steve Martinez, Licensed Acupuncturist
KM Building 40 2nd Street East Suite #225, Kalispell, Montana, 59901 (406) 270-1655

Patient Information:

Patient Name: ______________________________ Today's Date:___/___/___
(First) (Middle) (Last)

Address: ______________________________
(Street) (City) (State) (Zip Code)

Phone Numbers: Home__________________ Work__________________ Cell__________________

Date of Birth: ___/___/___ Age: _____ Patient's Occupation: __________________

If Patient is a minor: Mother's Name: __________________ Father's Name__________________

Do you have children? Y ___N___

Primary Care Practitioner: ______________________________

Who referred you? ______________________________

In an emergency whom should we notify? ______________________________

Relationship to you? __________________ Phone: __________________

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1. Main Problem(s) you would like help with. ______________________________

____

2. When did the problem(s) begin? Please be specific. ______________________________

____

3. To what extent does the problem(s) interfere with your daily activity? (work, sleep, etc.) __________

____

4. Have you been given a diagnosis? If so, what? ______________________________

____

5. What kinds of treatments have you tried? ______________________________

____

6. Medication taken in the last two months: ______________________________

____
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7. Vitamins and/or herbs taken in last two months.:_____

_____

8. Serious illness/injury (date and outcome):_____

_____

9. Hospitalizations (year and reason): _____

_____

10. Allergies to medication or other substances: _____

_____

11. Significant dental work (date and outcome): _____

_____

12. Do you have occupational concerns? (Please check if your work exposes you to any of the following.)
Stress ___ Hazardous Substances___ Heavy Lifting___ Other ___ (_____)

13. Do you have a regular exercise program? Y___N___ Please describe. _____

_____

Do you have any of the following conditions?

1. ___Bleeding Disorder 2. ___Diabetes 3. ___Pacemaker

4. ___Loss of Feeling Anywhere (if so, where?) _____ 5. ___Anemia

If you are here for pain please indicate on this scale how severe it is. (0 being no pain, 10 being really bad.)

0|----------|10

Please indicate on the body scale below any painful or distressed areas.