

Harris Gibson
Board Certified Acupuncturist
856.649.9896

Note: information provided on this form is confidential.

Today's Date ___/___/___

Name: _____ Age: _____ Sex: Male Female

Address _____ Occupation _____

City _____ State _____ Zip _____ Date of birth ___/___/___

Telephone: Day _____ Ext. _____ Evening: _____ e-mail _____

How did you hear about us? _____

Under a physicians care? _____ Name & phone of physician: _____

What would you like treated by Acupuncture? _____

How long have you had this condition? _____ Was onset sudden gradual

Symptoms are worse by _____ Symptoms better by _____

What medical diagnosis have you received? _____

What other treatments have you received for this and/or other conditions? _____

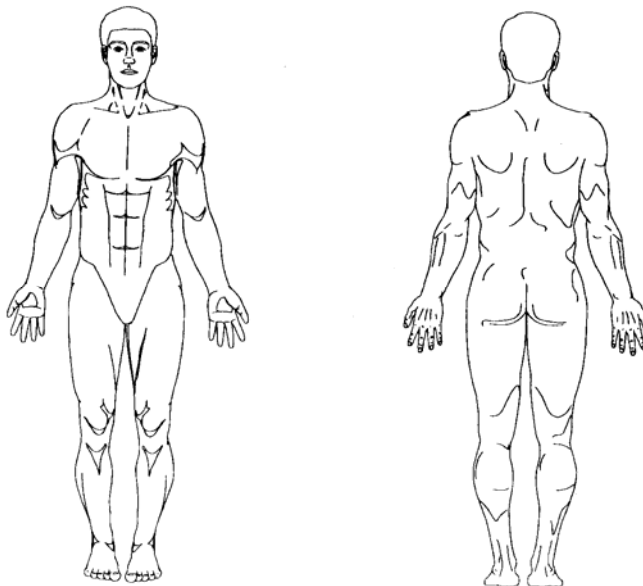
How has this condition changed your life? _____

Are you taking any medication? Please note all medication, herbs, vitamins and minerals you take even if you take them only occasionally. _____

Are you currently pregnant? Yes No

Are you presently trying to get pregnant? Yes No

On the following drawing shade the areas which you feel should be addressed.



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Medical History

Birth: Anything significant about your birth? _____

Vaccination history: Any reaction that you remember? Any unusual vaccination? _____

Childhood illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Adolescence illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Adulthood: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Family history: please note all major illnesses in your close family such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.
