Santa Fe Soul
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Patient Information

IDENTIFICATION DATA:

Date:_____/_____/_____
Name:_____SS#:_____
Age:_____ Date of birth:_____Ht:_____Wt:_____ Gender: ❑❑ M ❑❑ F
Marital Status: ❑❑ Single ❑❑ Married ❑❑ Divorced ❑❑ Widowed ❑❑ Living with
Street Address:_____
City:_____State:_____Zip:_____
Home Phone:_____Business Phone:_____Email:_____
Occupation:_____❑❑
Retired Emergency Contact Name & Phone:_____
_____

Referred by:_____
Have you had acupuncture before? ❑❑ Yes ❑❑ No Chinese herbal medicine? ❑❑ Yes ❑❑ No

Reason for visit today:_____
_____
_____
_____

Is it getting worse? ❑❑ Yes ❑❑ No Does it bother your ❑❑ Sleep ❑❑ Work ❑❑ Other:_____
_____

Have you been given a diagnosis for this problem? If so, what?_____
_____
_____

Other complaints?_____
_____
_____

Are you under the care of a physician now? ❑❑ Yes ❑❑ No If yes, for what?_____
_____

PERSONAL/FAMILY HISTORY: Please complete for yourself and each family member.

	Self	Father	Mother	Brother(s)	Sister(s)	Children
Allergies	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Asthma/Bronchitis	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Blood disorder/Anemia	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Diabetes	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Cancer or Tumors	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Epilepsy/Seizures	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Cont'd	Self	Father	Mother	Brother(s)	Sister(s)	Children

High Blood Pressure	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Kidney/Bladder Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Stomach/Intestinal Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Drug/Alcohol Addiction	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Tobacco Addiction	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Arthritis	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Heart Disease/Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Stroke	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Thyroid Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Skin Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Hepatitis	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Kidney Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Urinary Tract Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Tuberculosis	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Musculo-Skeletal Disorder	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Headaches/Migraine	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Transfusion	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
AIDS/HIV	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Arteriosclerosis	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Birth Trauma	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Emphysema	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Herpes	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Ulcers	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑
Pacemaker	❑❑	❑❑	❑❑	❑❑	❑❑	❑❑

❑❑ Other:_____

Current Medications:_____

_____

_____

_____

Vitamins/Supplements:_____

_____

_____

MAJOR HOSPITALIZATIONS:

Please indicate if you have been hospitalized for any serious medical illness or operation.

Date:_____Operation/Illness:_____
Date:_____Operation/Illness:_____
Date:_____Operation/Illness:_____
Date:_____Operation/Illness:_____

❑❑ Please check here if you have had more than 4 such hospitalizations, and use the back of the form to complete.

Patient Signature:_____**Date**:_____/_____/_____

WITHOUT EXCEPTION, ALL INFORMATION IS STRICTLY CONFIDENTIAL. THANK YOU.