



ZOE COHEN, L.AC. 510 326 7022
ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE

NAME.....SEX.....BIRTH DATE.....AGE.....
ADDRESS.....CITY.....STATE.....ZIP.....
CELL PHONE.....HOME PHONE.....
EMAIL.....OCCUPATION/EMPLOYER.....
EMERGENCY CONTACT.....PHONE.....
REFERRED BY.....HAVE YOU USED ACUPUNCTURE OR CHINESE HERBS BEFORE?.....

Primary reason for your visit?

Other complaints?

Please list any major surgeries, hospitalizations, illnesses, injuries, emotional trauma:

Please list all current medications and medications used long-term in the past:

Please list any supplements (e.g., vitamins, herbs) used:

Do you consider your diet to be balanced? And do you have any dietary restrictions? (e.g., vegetarian):

Please describe your use (if at all) of alcohol, caffeine, cigarettes, drugs:

Please list any allergies (e.g., food, drug, environmental):

Number of pregnancies: Number of births:

Is there anything else you think is important for me to know?

*If you need to cancel your appointment, please be sure to give at least 24 hours notice, otherwise you will be charged for the missed visit.

SIGNATURE.....DATE.....