SYNTHESIS MEDICAL ACUPUNCTURE

Personal History Questionnaire

Patient Information Today's Date _____

Name: _____ Date of Birth: _____

Age: _____ ❑ Male ❑ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work or Cell Phone: _____

Email Address: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other _____

Your Occupation: _____Your Employer: _____

Referred to this office by: _____

Name of Insurance: _____

Please Describe Present Major Health Concerns

Please Rate Your Symptoms (1-10 with 1 being least serious)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Please list any physicians you are currently seeing and the reason for their care:

_____

_____