Patient Information

CONFIDENTIAL

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Welcome!

Please take a moment to provide some information about yourself and your health conditions. Axis Acupuncture considers this information privileged physician-patient communication and will hold it confidential.

NAME (LAST, FIRST, MI)	DATE

AGE	DATE OF BIRTH	GENDER MALE FEMALE

PHONE	E-MAIL ADDRESS

HOME ADDRESS		
CITY	STATE	ZIP

OCCUPATION	BUSINESS PHONE

EMPLOYED BY		
BUSINESS ADDRESS		
CITY	STATE	ZIP

SPOUSE OR PARTNER'S NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE

HOW DID YOU FIND SARAI AND AXIS ACUPUNCTURE?

( ) FRIEND ( ) PHYSICIAN OR OTHER PROFESSIONAL ( ) CITYSEARCH ( ) WEBSITE ( ) ______________________

ADDITIONAL INFORMATION

I understand that I should be evaluated by a western medical physician for the condition which I am requesting consultation. The diagnosis and treatment plan I will be given is based upon Traditional Chinese Medicine and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am taking.

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SIGNATURE DATE