

### Patient Information Card

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MALE / FEMALE

PRIM. PH# \_\_\_\_\_ OTHER PH# \_\_\_\_\_ EMAIL: \_\_\_\_\_


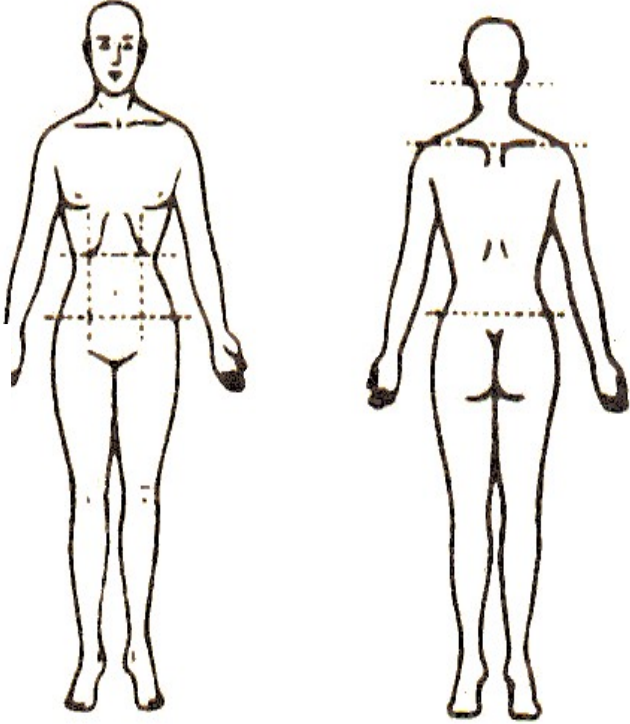
ST. ADDRESS: \_\_\_\_\_ SS # \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ DOI : \_\_\_\_\_ CLAIM # \_\_\_\_\_ ATTY: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PH# \_\_\_\_\_

  DIAGNOSIS  _____  _____  _____  _____	TONGUE _____	
	COLOR: _____	
	COAT: _____	
	BODY: _____	
	PULSE _____	
	RIGHT: _____	
	LEFT: _____	

COMPLAINS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Information Card**

<b>Date of Visit</b>													
Acupuncture													
Electric Acupuncture													
Acupuncture Add Time													
Manual Therapy													
Massage Therapy													
Moxi Busion													
Cupping													
Infrared Heat													