



Shohreh Doustani M.S. L.Ac.
shohrehdoustani.com

Today's Date

Name **SS#** **DOB**

Marital Status: Sex:----F ----M

Address
City, State, Zip

Home Phone Cell Phone Occupation
Email Address (please print)

Emergency Contact Name & Phone

Referred by:

Have you had acupuncture/Chinese herbal medicine before? ---- Yes ----- No

Reason for visit today:

How long have you had this condition?

Is it getting worse? Does it bother your: ---- Sleep ----- Work ---- Other

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Are you under the care of a physician now? ---- Yes ---- No

If yes, for what?

Who is your physician? Physician's Phone:

Please list medications you are currently taking and the reason you are taking them:

Other concurrent therapies:

Health Insurance Info:

Insurance Co. Name

Policy #

Address

Phone

City, State, Zip





Shohreh Doustani M.S. L.Ac.
shohrehdoustani.com

Family Medical History

(Check any of the following conditions your **family member** have, or have had in the past. Please also indicate the relationship of the family member, for example mother, father, grand parents...)

- Allergies (explain)
- Arteriosclerosis --- Cancer --- Diabetes --- Seizures
- Asthma --- Heart Disease --- Stroke --- Alcoholism
- High Blood Pressure

Your Medical History

(Check any of the following conditions you **currently have, or have had in the past.** Please also check if you feel any of the following are a significant part of your medical history.)

- Allergies(explain):
- Surgery (list):
- Major Trauma (list):
- Birth Trauma (list):
- Thyroid Disorders (list):
- Hepatitis (A B C E)

---AIDs/HIV	---Diabetes	---Multiple Sclerosis
---Tuberculosis	---Measles	---Scarlet Fever
---Alcoholism	---Herpes	---Mumps
---Epilepsy	---Appendicitis	---Chicken Pox
--- Seizures	---Goiter	---Whooping Cough
---Stroke	---Ulcers	---Typhoid Fever
---Emphysema	---Gout	---Polio
---Pneumonia	---Heart Disease	---Rheumatic Fever
---Pleurisy	--- Pacemaker	---Cancer
---Asthma	---High Blood Pressure	

- Other (Specify)

I certify that the above information is complete and accurate.

Patient Signature:

Date:

