WILLIAM PRANGE, OMD,LAc

LICENSED ACUPUNCTURIST
DOCTOR OF ORIENTAL MEDICINE

TODAY'S DATE ____________

NEW PATIENT INTAKE FORM

NAME ____________ BIRTHDATE ____________ AGE ______

ADDRESS ____________ HEIGHT ______ WEIGHT ______

CITY, STATE, ZIP ____________ OCCUPATION ____________

HOME PHONE ____________ WORK PHONE ____________

CELL PHONE ____________ EMAIL ____________

EMERGENCY CONTACT (NAME & PHONE) ____________

REFERRED BY ____________

REASON FOR TODAY'S VISIT ____________

HOW LONG HAVE YOU HAD THIS CONDITION? ____________

IS IT GETTING WORSE? ____________

DOES IT BOTHER YOUR SLEEP? ______ WORK? ______ OTHER (WHAT)? ____________

WHAT SEEMED TO BE THE INITIAL CAUSE? ____________

WHAT SEEMS TO MAKE IT WORSE? ____________

WHAT SEEMS TO MAKE IT BETTER? ____________

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? YES ___ NO ___ IF YES, FOR WHAT? ____________

PHYSICIAN'S NAME ____________ PHONE ____________

OTHER CONCURRENT THERAPIES ____________

HAVE YOU HAD ACUPUNCTURE BEFORE? ____________ CHINESE HERBAL MEDICINE? ____________

SIGNATURE TO RELEASE MEDICAL INFORMATION: I hereby authorize the release of any medical information necessary to process my records. I understand that by signing this form I declare that I am responsible for the payment of services received. ____________

NOTICE OF PRIVACY PRACTICES: I have received a copy of the notice of privacy practices ____________
I have elected not to receive a copy of the notice of privacy practices ____________