



**Atlas Acupuncture**  
**Susan Atlas, M.Ac., L.Ac., RN**

**PATIENT INTAKE  
 FORM**

Date \_\_\_ / \_\_\_ /200\_\_

**PERSONAL INFORMATION**

All answers are confidential. Please print clearly in ink.

Name					Sex		Email	
Address					City		State Zip	
Telephone: Home ( ) -			Work ( ) -		Cell ( ) -			
Birth Date			Age					
Single	Married		Partnered		Separated/Divorced		Widowed	
Education					Occupation			
Emergency contact					Relationship			
Telephone: Home ( ) -					Cell ( ) -			
Name of Physician:							(Physician contact will not be made without your permission.)	
Address:								
Telephone: ( ) -								
Date of last physician appointment:								
last gynecology exam:								

**MEDICINES:**

**PRESCRIPTION DRUGS (current)**

**Purpose**


**OVER-THE-COUNTER**

**Medications, Herbs, Supplements (current)**

**Purpose**




**FAMILY HISTORY: Please indicate any illnesses you and your family members ever had.  
Place an "X" or the date in the appropriate box or boxes.**

	self (date)	mother	father	siblings	spouse	Children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Deceased (age and year)						
Hepatitis						
Kidney disorders						
Thyroid disorders						
Musculoskeletal disorders						
Blood transfusion (before 1985)						
Other:						

**OTHER INFORMATION:**

**Have you ever had acupuncture and/or Chinese herbal medicine treatment before?**

**Please add anything else you would like me know about.**

**Who may I thank for this referral?**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**