ACUPUNCTURE and MASSAGE INTAKE FORM

Name: _____ DOB:_____

Briefly explain the reason for your appointment today:_____
_____

Have you seen any other health care providers for this condition? ☐ No ☐ Yes, please list:

_____
_____

Past serious illnesses, surgeries, or hospitalizations? ☐ No ☐ Yes, please list:

_____
_____

Are you currently being treated for any health concerns other than the reason for your visit? ☐ No ☐ Yes, please list:

_____
_____

Please list all medications or supplements which you are currently taking:

_____
_____

If allergy treatment is NOT the reason for your visit, please list any allergies you have:

_____
_____

Is today's visit because of a work injury?_____ Auto Accident?_____
Date of Injury:_____
Please indicate if you have a past history (circle all that apply):

Headaches	High Blood Pressure	Bleeding Disorders
Heart Problems	Lung Problems	Hearing Problems
Ulcers	Reproductive Disorders	Psychiatric Problems
Frequent Illness	Bad Scarring	Thyroid Problems
Emotional Problems	Circulatory Problems	

Comments: _____
_____
_____

CANCELLATION POLICY

It is the policy of Greg Bourque to require payment in full for any service if a cancellation is made within 24 hours of the scheduled appointment time.
Signature_____ **Date**_____