Acupuncture & Alternative Medicine

250 W. Lancaster Avenue, Suite # 150 Paoli, Pa 19301
Phone: 610-296-8833 Fax: 610-296-3966

Patient Information Sheet (Please print clearly)

First Name_____ Last Name_____
Date of Visit_____ Date of Birth_____ Male/Female
Phone Number:
Home_____ Office _____ Cell_____
Email Address_____
Would you like to receive the doctor's monthly electronic health newsletter that includes periodic promotions? Yes / No
Address:
Street _____
City_____ State _____ Zip Code _____
Referred By (Name) _____
Physician( ) Friend( ) Phonebook( ) Internet( ) Other( )

Main Problem(s) you would like help with:_____

_____

_____

How long ago did this problem begin (be specific)?_____

_____

Have you been given a diagnosis for this problem: If so, what? _____

_____

What kind of treatments have you tried?_____

_____

Past Medical History (please circle and include date):

Cancer_____ Diabetes_____ Hepatitis A B C _____
High Blood Pressure_____ Heart Disease_____ Pacemaker_____
Thyroid Disease_____ Seizures_____
HIV/AIDS_____ Other_____

Comments:_____

_____

_____

Payments are expected at the time of treatment. Please inform us one day in advance if you are unable to keep your appointment. Thank you.

Signature: _____ Date_____

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