acupuncture
SHREVEPORT

745 Olive Street, Suite 212 | Shreveport, LA 71104
318.459.9125 | www.shreveportacupuncture.com

Ofc. use, Patient No.: _____

Full Name _____ Date of birth _____ Age _____

Street Address _____ Phone (_____) _____

City _____ State _____ Zip _____

Email Address _____ Cell Phone (_____) _____

Occupation _____

Emergency Contact _____ Phone (_____) _____

Have you had acupuncture before? Yes_____ No_____

FOR OFFICE USE

Have you experienced any of the following in the last two months?

☐ Headache	☐ Low appetite
☐ Fever	☐ Gas/bloating
☐ Chills	☐ Constipation
☐ Cough	☐ Diarrhea
☐ Heart palpitations	☐ Acid reflux
☐ Night sweats	☐ Depression
☐ Poor memory	☐ Anxiety
☐ Poor concentration	☐ Restlessness
☐ Bladder dysfunction	☐ Cold hands & feet
☐ Erectile dysfunction	☐ Vivid dreams

Reason for seeking treatment _____

_____

Is your blood pressure usually high _____ normal _____ low _____

List all medications and supplements _____

_____

_____

List known allergies _____

_____

List surgeries _____

_____

List chronic or recurring conditions (examples: diabetes, asthma, migraines)_____

_____