Patient Information Card

LAST NAME:_____ FIRST NAME:_____ MALE / FEMALE

PRIM. PH#_____ OTHER PH#_____ EMAIL: _____

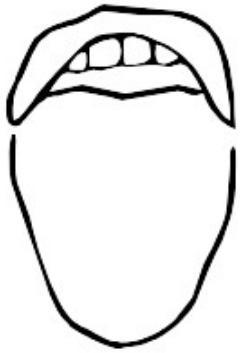
ST. ADDRESS:_____SS # _____ BIRTHDAY_____

CITY: _____ STATE_____ __ ZIP _____ OCUPATION: _____

EMPLOYER: _____DOI : _____CLAIM # _____ ATTY: _____

INSURANCE: _____ID #_____GROUP # _____

PRIMARY PHYSICAN: _____ PH#_____



DIAGNOSIS

_____

_____

_____

_____

_____

_____

____TONGUE_____

COLOR:

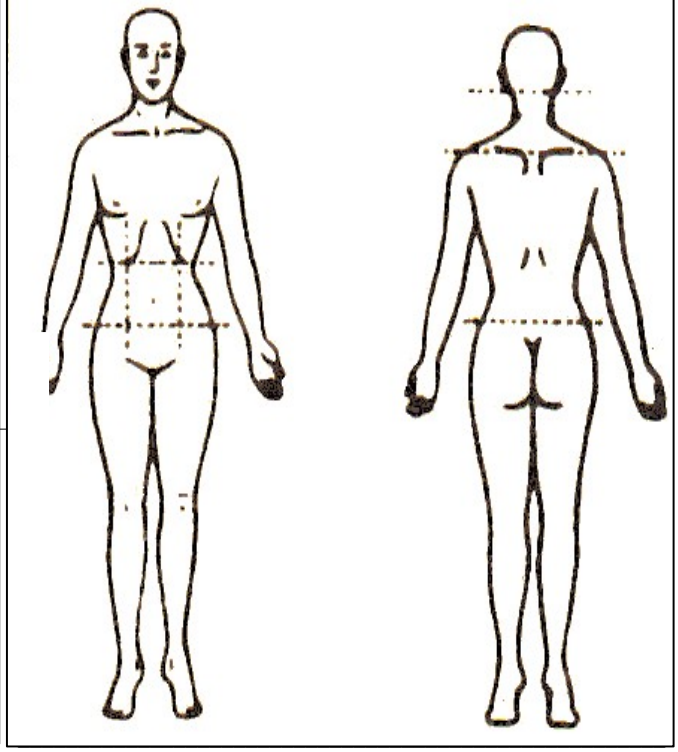
COAT:

BODY:

PULSE

RIGHT:

LEFT:



COMPLAINS:

_____

_____

Date of Visit	Acupuncture	Electric Acupuncture	Acupuncture Add Time	Manual Therapy	Massage Therapy	Moxi Bustion	Cupping	Infrared Heat	Patient Information Card