【 Patient Information Form 】

yy／mm／dd

Name :	**Date of Birth** :
Address :	**Home** : **Cell** :

Bill : Indicate how often will you need a receipt?

1.Not necessary 2.Once a year 3.Once a month 4.Every time

Occupation :	**Referred by** :

How did this injury occur?

・Twiste ・A fall ・You were hit
・Fell from a high place
・Lifting a heavy object
・Muscle pain／Pulled or torn muscle
・Woke up with pain
・Strained back
・Traffic accident
・Other

When did this happen?

1.Today
2.Yesterday
3.Two days ago
4.Three days ago
5.A week ago
6.More than a week
When?

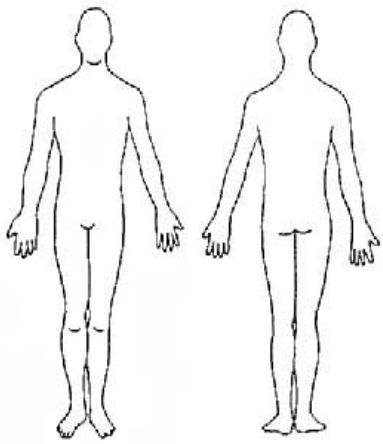
_____

Where ?

1.Own home 2.At work
3.At school 4.On the road
5.Somewhere else

_____

Using a circle,Please indicate where You feel pain.



When it comes to this injury specifically ,Have you sought treatment elsewhere.If so ,where?

_____

Have you ever received acupuncture ,A massage,or electrotherapy before?

_____

Do you have a pre-existing medical condition?

_____

Have you done acupuncture before or are you interested in it? Yes ・ No

For this injury, What symptoms are you experiencing? (Please indicate all this apply.)

・ Stiff shoulders	・ Headache	・ Backache
・ Sansitive to cold	・ Constipation	・ Insomnia
・ Fatigue	・ Lose of appetite	・ Menstrual pains
・ Nerve pain	・ Indigestion	・ Chronic allergies
・ Neurosis	・ Obesity	・ Other _____

If you have any request, or additional information,Please use this space.

Ishido osteopathic clinic／Ishido acunpuncture and moxibustion clinic