ACUTHERAPY & HERBAL CLINIC
CLIENT'S INFORMATION (CONFIDENTIAL)

Last Name _____; First Name_____; Initial _____

Sex: ☐M; ☐F; Date of Birth (mm/dd/yyyy) _____ Occupation _____

Address _____ Postal Code _____

Phone (Home) _____; (Work/Cell) _____

Email: **_____**

Health Questionnaire:

Are you hypersensitive or allergic to _____

Female Reproduction: How many days of Period Cycle _____days, ☐ regular; ☐ Irregular (Optional)

Duration of Period (bleeding) _____

First day of the Last Period (mm/dd/yyyy) _____

Male Reproduction: ☐ Impotence; ☐ Premature Ejaculation; ☐ Sperm abnormal (Optional)

Medical History & Complaint or Diagnosis: _____

_____

You know about us through:

☻ ☐Google; ☐MSN; ☐Yahoo; ☐Yelp; ☐others._____

☻ Recommended by: ☐ Family Dr.; ☐ Specialists; ☐ Friends_____; ☐others _____

☻ Any other ways: _____

Authorization for Acutherapy:

I, the undersigned, consent to the proscribed treatment with acutherapy (acupuncture, Chinese massage, cupping, moxibustion, or/and herbs) by a representative of Acutherapy & Herbal Clinic. Jenny Zhang or Michael Ma has explained the nature and anticipated effects of the treatment to me and I understand the explanation.

Signature _____ Date _____