PATIENT INFORMATION FOR AURICULOTHERAPY

DATE:____________________

LAST NAME:___________________________ FIRST NAME:_________________________ MI:_________

ADDRESS:____

CITY:____ STATE:_______________ ZIP:_________________

PHONE:(______)_________________________ DAY TIME PHONE #:________________________________

BEST TIME TO CALL?_______________________ OK TO LEAVE MESSAGE? YES ___ NO___

MALE___ FEMALE___ AGE:__________ DATE OF BIRTH:________________________

MARITAL STATUS: S M D W SEPARATED LIFE PARTNER

EMERGENCY CONTACT:_____________________________________ TEL #:_________________________

SOCIAL SECURITY #:_________________________ OCCUPATION:________________________________

EMPLOYER:____

EMPLOYER ADDRESS:____

EMPLOYER PHONE NUMBER:_______________________________

SPOUSE'S NAME:____

SPOUSE'S DATE OF BIRTH:__________________________ SS#:___________________________________

SPOUSE'S OCCUPATION: ____

SPOUSE'S EMPLOYER: ____

WHOM MAY WE THANK FOR REFERRING YOU? ____

ARE YOU PREGNANT?____________________

DO YOU HAVE A PACEMAKER?____________

HABITS *(check all that apply)*:

___ SMOKING PACKS PER/DAY __________
___ ALCOHOL DRINKS/PER WEEK __________
___ COFFEE/CAFFEINE DRINKS CUPS/DAY __________
___ HIGH STRESS LEVEL REASON ____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS