

MEDICATIONS/SUPPLEMENTS CURRENTLY TAKING			
HABITS	CURRENT	PAST	FREQUENCY
Cigarettes			
Alcohol			
Caffeine			
DIET	LIST FOODS EATEN ON A TYPICAL DAY		
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Restrictions			
Cravings			

DATE OF LAST PHYSICAL EXAM	
Name of Doctor	_____
Address	_____
Phone	_____

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment.

To comply with Article 160, Section 8211.1 (b) of the NYS Education Law, we request that you read and sign the following statement:

I/We, the undersigned, do affirm that (patient) \_\_\_\_\_ has been advised by Thomas Droge, L.Ac. to consult a physician regarding the condition(s) for which above named patient seeks acupuncture and/or herbal medicine treatment.

\_\_\_\_\_  
**(patients's signature)**

\_\_\_\_\_  
**(date)**

\_\_\_\_\_  
**(L.Ac's signature)**

\_\_\_\_\_  
**(date)**

### IDENTIFICATION DATA

Name \_\_\_\_\_ Education \_\_\_\_\_  
 Address \_\_\_\_\_ Todays Date \_\_\_\_\_  
 City/Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Age \_\_\_\_\_  
 Mobile Phone \_\_\_\_\_ Place of Birth \_\_\_\_\_  
 Gender \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Partner Status \_\_\_\_\_ Email Address \_\_\_\_\_

### FAMILY HISTORY

AILMENT	FATHER	MOTHER	SIBLING	CHILDREN	OTHER
Allergies					
Blood Disorder					
Diabetes					
Cancer/Tumors					
Seizures					
High Blood Pressure					
Kidney/Bladder					
Stomach/Intestinal					
Drug Abuse					
Tuberculosis					
Heart Disorder					
Stroke					
Other					
Age of Death					

### PERSONAL HEALTH HISTORY

Allergies (Food/Drug) Asthma Cancer Herpatitis Diabetes Thyroid  
 Digestive Tuberculosis Seizures Stroke High Blood Pressure Other  
 Hospitalizations \_\_\_\_\_  
 Date \_\_\_\_\_ Illness \_\_\_\_\_ Hospital/Clinic \_\_\_\_\_  
 Pregnancy History / Number of Children \_\_\_\_\_  
 Reason for seeking treatment today \_\_\_\_\_

### REFERRAL INFORMATION

Referred by: \_\_\_\_\_