THE HARBOUR CLINIC SHORT INTAKE

Name_____Date of Birth_____

Address_____City/State/Zip_____

Email_____ Age_____ M/F

Home phone_____Cell phone_____

Emergency contact/phone #_____

Pregnant? _____ On Blood Thinners? _____ Allergic to Latex? _____ Stress Level 0-10_____

History of heart issues?_____ Do you have a pacemaker?_____ Implants?_____

Any Piercings (other than ears)? If so, where?_____

Do you have: Cancer? _____ Hepatitis A,B,orC?_____ HIV?_____ Other?_____

List accidents, surgeries, major illnesses:_____

_____

Medications/Supplements/Herbs _____

_____

How much water do you drink per day? _____ glasses. Do you exercise? _____

Eat/drink dairy? _____ Do you use ice? _____ Have you ever had acupuncture? _____

CHIEF COMPLAINTS HOW LONG HAVE YOU HAD THIS INTENSITY 0-10

1._____/_____/_____

2._____/_____/_____

3._____/_____/_____

If you have pain, where is it located? _____

_____

(If you need more space for answers, please use back of page)

Signature_____ Date _____