MAYAN MOON HEALING

PH: 847.868.0528 Web: www.MayanMoonHealing.com

Please Print

PERSONAL INFORMATION

First Name: _____ Last Name: _____ Gender: ☐ Male ☐ Female

Home Number: _____ Mobile Number: _____ Work Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: _____ Occupation: _____

Employer: _____ Email: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

How did you hear about us? _____

HEALTH HISTORY

Reason for visit: _____

Have you seen a physician for your current complaint? ☐ Yes ☐ No

If yes, what is your physician's name? _____ What is your medical diagnosis? _____

How long have you been under their care? _____ Is this condition getting worse? ☐ Yes ☐ No ☐ Comes & Goes

Please Explain: _____

Current Medications: _____

Do you take any Vitamins or Herbs? _____

Serious Illness / Injuries / Surgeries: _____

Have you ever been under acupuncture care? ☐ Yes ☐ No

If Yes, Name of Practitioner: _____ How long ago was your last acupuncture treatment? _____

Do you have a cardiac pacemaker or any metal in your body (please list where)? _____

Do you currently experience any of the following symptoms?

Headaches	☐ Yes	☐ No	How Often _____
Fatigue	☐ Yes	☐ No	How Often _____
Pain (Specify Location: _____)	☐ Yes	☐ No	How Often _____
Insomnia or Difficulty Sleeping	☐ Yes	☐ No	How Often _____
Moodiness / Irritability	☐ Yes	☐ No	How Often _____
Digestive Problems	☐ Yes	☐ No	How Often _____
Sinus / Allergy	☐ Yes	☐ No	How Often _____

Please check off any of the conditions you have now or have had in the past:

○ Diabetes	○ Hepatitis	○ Autoimmune disease
○ Eating disorder	○ Fibromyalgia	○ Chronic fatigue syndrome
○ Heart disease	○ MRSA	○ Stroke
○ Peripheral neuropathy	○ Dementia	○ Arthritis
○ Carpal tunnel syndrome	○ Easy bruising or bleeding	○ Multiple sclerosis
○ Epilepsy/seizures	○ Anemia	○ Anxiety
○ Depression	○ Asthma	○ Kidney disease
○ IBS	○ Cancer	○ Other: _____ Other: _____

WOMEN ONLY

Are you, or could you be pregnant? _____ If so, how far along are you? _____

Total number of pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Have you ever had any gynecological surgeries or any abnormal findings on any tests? _____

_____

Do you have any gynecological concerns or complaints? _____

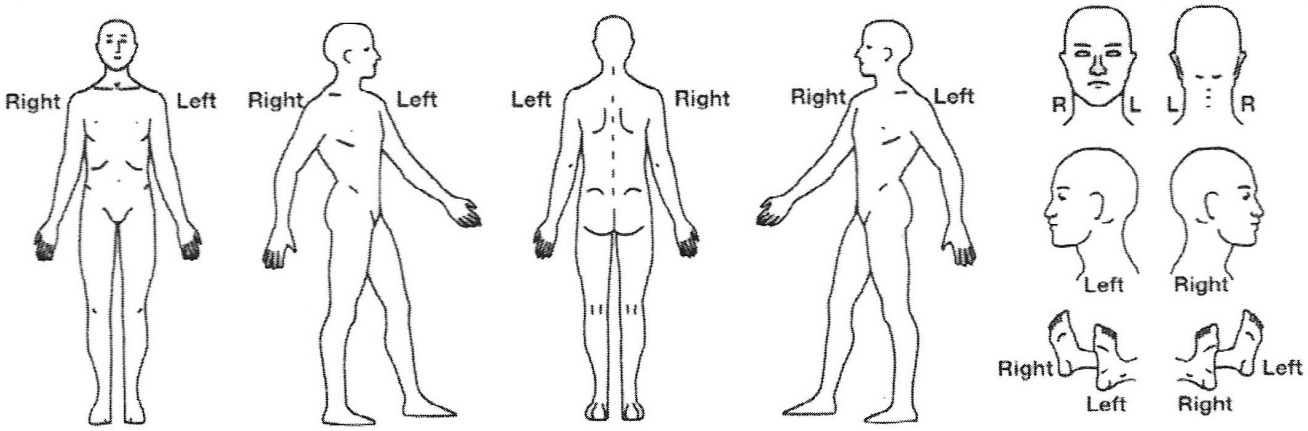
MEN ONLY

Do you experience any of the following?

- ☐ Reduced Libido
- ☐ Impotence
- ☐ Urinary Frequency
- ☐ Genital/ Testicular pain
- ☐ Excessive Libido
- ☐ Premature Ejaculation
- ☐ Discharge

Any other concerns? _____

Please mark or circle the areas needing attention during our session today on the diagram:



Is there anything that you feel we should know about your current or past health that we have not addressed or covered adequately in this form? _____

_____

_____

If you are unable to keep the appointment, please notify us 24 hours prior to your scheduled appointment. Thank you for your professional consideration, courtesy, and promptness.

I, _____, hereby acknowledge that all the above information is correct to my knowledge.
(Please Print)

Client's or Legally Authorized
Person's Signature: _____ Date _____