# Patient Information

CONFIDENTIAL

## *Welcome to Point Of Origin Acupuncture & Herbal Clinic*

***Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Point Of Origin Clinic considers this information privileged physician/patient communicationand will hold it in confidence.***

| NAME (LAST, FIRST, MIDDLE) | DATE |
|---|---|
| | |

| AGE | DATE OF BIRTH | SEX | MARITAL STATUS |
|---|---|---|---|
| | | ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed |

| PHONE | EMAIL ADDRESS |
|---|---|
| | |

| HOME ADDRESS | | |
|---|---|---|
| CITY | STATE | ZIP |
| | | |

| OCCUPATION | BUSINESS PHONE |
|---|---|
| | |

| EMPLOYED BY | | |
|---|---|---|
| EMPLOYERS ADDRESS | | |
| CITY | STATE | ZIP |
| | | |

| SOCIAL SECURITY NUMBER |
|---|
| |

| SPOUSE'S NAME |
|---|
| |

| CONTACT IN CASE OF AN EMERGENCY | RELATIONSHIP | PHONE |
|---|---|---|
| | | |

| ADDITIONAL INFORMATION/NOTES |
|---|
| |

I understand that I should be evaluated by a physiscian for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Point of Origin Clinic is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese Diagnosis and treatment as my sole remedy for the treatment i am seeking. I understand if no substantial improvement is made in the condition for which i am seeking consultation, I am to seek advice from a western medical doctor. Further, if i am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements i am currently taking.

SIGNATURE

DATE