Welcome to Ping Chao Acupuncture. To help me provide you with the best possible care, please fill out this form carefully. All the information will be kept confidential in your patient file. If you have any questions, please ask. Thank you for your time.

Personal Information File Number:_____

Last Name_____ First Name_____ MI_____ Today's Date_____

Address_____ City_____ State_____ ZIP_____

Phone (H)_____ Phone (W)_____ Cell Phone_____ Email_____

Date of Birth_____ Age_____ Sex_____ Height_____ Weight_____

Marital Status_____ Occupation_____ Social Security Number_____

Emergency Contact_____ Relationship_____ Contact Phone_____

Primary Physician _____ Phone Number_____ Date of Your Last Visit_____

Insurance Information

Primary Last Name_____ Primary First Name_____ MI_____

Patient Relationship to Primary Insured_____ Insurance Name_____ Plan Name_____

Subscriber ID_____ Group Number_____ Phone Number_____

Address_____ City_____ State_____ ZIP_____

Personal and Family Medical History

List illnesses and injuries of onset (list dates if possible)_____

List any operations not listed above_____

List medications you are taking, including over the counter medications, oral contraceptives, vitamins, supplements. Include dosage if possible._____

List allergies and medicine allergies_____
Are you a smoker (circle one)? Yes No

Check where applicable	Self	Mother	Father	Type	Comments (medications, surgery, treatments, etc)
Heart disease					
Anemia					
Cancer (and type)					
Diabetes					
High Cholesterol					
H or L Blood Pressure					
Tuberculosis					
Depression					
Hepatitis (and type)					
Insomnia					
Stroke					
Hypo thyroid					
Hyper thyroid					
Other					