Renae Einspahr
Five Element Acupuncture Allergy Elimination

100 Acoma Street
Denver, CO 80223
(720) 371-0917

PATIENT INFORMATION

Name _____Date_____

Address _____ _____

City _____ State_____ Zip Code_____

Phone (H)_____ (W)_____ (Cell)_____

Email _____ _____Age_____ DOB_____

Occupation_____Employer_____

Employer Address_____

Emergency Contact _____Phone_____

Referred by_____

Are you currently receiving health care? Y N

Condition being treated_____

Name of Physician _____

What are your most important health concerns?

1. _____
2. _____
3. _____
4. _____

Please list tested or suspected allergies and related symptoms:

Foods_____

Seasonal_____

Drug/other _____

Current Medications: Please list any prescription medications or OTC medications you are taking.

_____

_____

_____

_____

Do you smoke? Y N Do you wear contacts? Y N

Do you have pets? If so what type? _____

Signature _____ **Date**_____
(under the age of 16 must be signed by Parent or Legal Guardian.)