JI SUNG KIM ACUPUNCTURE, P.C.

330 W 58th St Ste 610
New York, NY 10019
Tel: +1 646-609-2154

This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you.
If you have questions, please ask. Thank you.

Patient Information

Name:_____Sex: Male___Female_
Date of Birth:_____Height:_____Weight:_____
Home Address:_____
City:_____State:_____Zip:_____
Home Phone:_____Cell/Work Phone:_____
Email:_____
Emergency Contact Name:_____Phone:_____
Patient Employer/School :_____Occupation:_____
Employer/School Address:_____
Whom may we thank for referring you to us:_____
Marital Status: Married ___Single ___Divorced ___Widowed ___Number of children:_
Have you received acupuncture treatment before: Yes___ No___ When:_____

Reason for visit:_____
_____
First onset:_____
_____

Medical History

Please indicate any significant illnesses you or blood relatives have had:

	You	Relative	Date		You	Relative	Date
Cancer	_____	_____		Diabetes	_____	_____	
Hepatitis	_____	_____		Heart Disease	_____	_____	
High Blood Pressure	_____	_____		Seizures	_____	_____	
Rheumatic Fever	_____	_____		Emotional Disorders	_____	_____	
Infectious Diseases	_____	_____		Tuberculosis	_____	_____	

Sexually Transmitted Diseases:
Gonorrhea __ Syphilis __ HIV __ HPV __Chlamydia __Herpes __Date: _____

List ant medications and supplement you are currently taking:

Medicine	**Dosage**	**Reason**	**How long**	**Prescribed by**	**Date of last checkup**

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Surgery_____

_____

_____

Please check if any of the following statements are true:

I have known allergies ____ I am taking Coumadin/warfarin ____

I have a pacemaker ____ I am taking lithium(Eskalith,Lithobid,Lithonate,Lithotabs)___

Please indicate the use and frequency of the following:

		How much			How much
Coffee/black tea	Yes/No	_____	Tobacco	Yes/No	_____
Water intake	Yes/No	_____	Soda	Yes/No	_____
Non-medical drugs	Yes/No	_____	Alcohol	Yes/No	_____