

**VLASTA FENCL, L.Ac.**

**PATIENT RECORD**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_ Social Security # \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Referred by \_\_\_\_\_

Please answer the following questions by circling the appropriate answer:

Do you have a tendency to faint?	Yes	No	Are you HIV-positive?	Yes	No
Do you have a pacemaker?	Yes	No	(Women) Are you pregnant?	Yes	No
Do you bleed for a long time?	Yes	No	Do you have a seizure disorder?	Yes	No
Have you ever had hepatitis?	Yes	No	Do you have any allergies?	Yes	No

Please list all medications and supplements that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Have you had any surgeries? Please explain:

\_\_\_\_\_

Please list all major illnesses and/or injuries that you had in the past:

\_\_\_\_\_

What is your chief complaint?

\_\_\_\_\_

\_\_\_\_\_