Well Family Care Corporation

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15338 Central Ave., Chino, CA 91710
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Patient Name: _____ Date: _____

Address: _____ Birthday: _____

_____ Gender: _____ F _____ M

Phone (Home/Cell): _____ S.S. No. _____

Email: _____ Employed By: _____

Emergency Contact Person and Phone: _____

Reason for Visit/ What kind of symptoms do you have?

_____

_____

How long have you had these symptoms? _____

Have you been treated for these symptoms? _____

How would you grade your pain level (0-10)? _____ If yes, what kind of treatment? _____

What is your doctor's diagnosis? _____ Do you smoke now? ___Yes, ___No

Have you ever had acupuncture treatment? ___Yes, ___No

If yes, have you ever faint or shock during acupuncture? ___Yes, ___No

Do you have any work compensation claim or lawsuit regarding these symptoms? ___Yes, ___No

For female, when was your last menstrual period? _____ Are you pregnant now? ___Yes, ___No, ___Unknown

Please list any medications you are taking:

Medication	Dosage	Reason	Date started

Please list any surgeries/hospitalizations you have had:

Surgeries/Hospitalizations	Reason	Date

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

I understand the insurance coverage may be different if the deductible has not been met; annual maximum has been met, or if the coverage table is lower than average. Insurance verification is not a guarantee of payment. I am responsible for any charges not paid by the insurance company.

Patient Signature _____ Date _____