

**Lauren Berendt L.Ac.
Centerpeace Yoga and Wellness
1591 Oh-59 Kent, OH. 44240
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New Patient Intake

Name _____ **Today's Date:** ____ / ____ / ____

Address _____ **City** _____ **State** _____ **Zip** _____

Birthdate ____ / ____ / ____ **Age** ____ **Sex** ____ **E-mail** _____

Cell Phone _____ **Home Phone** _____

Occupation _____ **Employer** _____

Employer Phone _____

Primary Care Physician _____ **Phone** _____

Date of last physical exam: ____ / ____ / ____

EMERGENCY CONTACT INFORMATION

Name _____ **Relationship** _____

Phone _____

How did you hear about us? _____

*Acupuncture is not a substitute for conventional medical diagnosis or treatment.

*We require full payment at the time of service. We accept cash, checks, Debit, Visa, MasterCard and Discover.

*Kindly give us a 24 hour notice of any cancellation or reschedule need.

Please indicate if you have any of the following:

Hepatitis Pacemaker High Blood Pressure Seizure Disorder

HIV/AIDS Pregnancy Blood Thinning Medications Implanted Medical Device

Allergies to:

Drugs/Medications: _____ Foods: _____

Animals: _____ Seasonal: _____

Why are you here for acupuncture services? (health concern, well-being concern – physically, mentally or emotionally)

Please describe your medical history or conditions in the space provided:

Please list all medications, nutritional supplements, herbs or homeopathics you are currently taking:

Are there any other concerns or significant information about your health or health history that you feel you need to communicate to me?