Asim Safdar L.Ac

Patient Intake Form

Name: _____ Date: _____

Date of Birth: _____

Cell Phone #_____ Home Phone#_____

Email_____ Address: _____

_____

City_____ State_____ Postal Code_____

Emergency Contact: _____ Phone_____

Primary Care Physician:

Name: _____ Phone: _____

Address: _____

Are you seeing any other health care or alternative medicine providers?

_____

May we communicate with other providers about your case and treatment?

Yes____ No _____

Main Symptoms/Concerns:

Current Medications/Supplements/Herbs

History: (surgeries, previous illnesses, family history etc)

Do you have hypertension or hypotension? If so, what is the average number?

Do you suffer from diabetic neuropathy?

Do you have a bleeding or a blood disorder such as hemophilia, Von Willebrand disease, sickle cell anemia or Thalassemia? Are you currently taking blood thinner medications such as coumadin/warfarin.

Are you pregnant?