

Magnolia Healing Arts, LLC
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1235 SE Division St., Suite 115
Portland, OR 97202

PATIENT INTAKE

Name: _____ Date _____
Date of birth: _____ Age: _____
Address: _____
Phone: Primary _____ Home/Cell/Work/ Other _____
Alternate _____ Home/Cell/Work/ Other _____
E-mail: _____
Emergency contact: _____ Phone: _____
Who may we thank for your referral? _____

Account Information

Out of Pocket Insurance Insurance – Self Bill /Flex Plan Other _____
Insurance Provider: _____ Phone# _____
Adjuster/Claim Representative: _____
Member ID# _____ Group # _____
Primary Policy Holder: _____ Date of Birth: _____
Relationship to Patient: _____
Address if different from patients: _____
Employer: _____ Phone# _____
Motor Vehicle Accident
Claim# _____ Date of Accident _____ State _____

Health History

Please list your primary health concerns: _____
Have you had acupuncture before? _____ What other forms of treatment have you sought out? _____
Please list any allergies you have _____

List any surgeries, accidents, or hospitalizations (include dates): _____

Do you have a history of abuse? _____ What type of abuse? _____

Do you smoke? _____ How many per day? _____

Do you drink coffee? _____ How many cups per day? _____

Do you drink alcohol? _____ How much per week? _____

How much water do you drink per day? _____

Please list all medications, supplements, and/or herbs you are taking, including over the counter drugs:

Rx/Herbs/Supplements	Dosage	Reason for taking them	How long	Prescribed by

Please list any significant illness you or a relative have had:

	Yourself	Relative	When
Cancer			
Seizures			
Diabetes			
Heart Disease			
Infectious Diseases			
HIV/AIDS			
Rheumatic Fever			
High Blood Pressure			
Emotional Disorders			
Hepatitis			