Bethany Richardson, L.Ac., Dipl.Ac.

582 Market St, Ste 314, San Francisco CA 94104 p. 510.388.6077
440 Grand Ave, Ste 401, Oakland CA 94610 p. 510.533.1390

Medical History

Confidential

Name_____ Sex M F Age:_____ Today's Date: _____
Address:_____ City:_____ Zip: _____
Home Phone:_____ Business Phone:_____
Birth date:_____
Social Security:_____
Occupation:_____ Referred by:_____

Have you ever had acupuncture before? Yes/No Are you pregnant? Yes/No
Have you tested positive for the HIV virus? Yes/ No Do you have any surgical implants? Yes/No

Who is your Western Family Doctor?_____ Gynecologist_____
In case of emergency, call.... _____ Telephone _____

Chief Complaint:_____

When did it start/ date of onset? _____
How did it develop? _____
Have you had this in the past? _____
What makes it better? _____
What makes it worse? _____
Is you condition: ____Getting worse ___Constant ___Comes and goes
What treatments have you already received? _____
If yes, when _____
What where the results of your past treatments?_____
_____

Drug, Food or Supplement Allergies

_____
_____
_____
_____

Medication or Supplement you are currently taking	Dosage	Date Started

Please check any family history you might have of the folowing conditions;
☐ Cancer
☐ Heart Disease
☐ Diabetes
☐ Auto-Immune (Lupus, Rheumatoid Arthritis, Hoshimoto's, MS)
☐ Thyroid Diseases