**Holly J. Brown, LAc, DOM (FL)**
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Name_____________________________________________ Date of Birth:__________________
Phone(home)___________________(work)____________________(cell)___________________
Address____________________________City___________________State____Zip Code_________
Email________________________________________Referred by________________________
Occupation_____________________________________Marital Status_____________________
Emergency Notification__________________________________________________________
Main Concerns_______________________________________Onset_______________________
_____________________________________________________________________________

Past Medical History (include dates):
Surgeries:____________________________________________________________________
Significant Traumas (auto accidents, falls, etc.):_________________________________________
Allergies (food, drug, chemical):________________________________________________
Pregnancies (births, miscarriages, abortions, etc.):_________________________________________
Cancer__________Diabetes___________Heart Disease__________High Blood Pressure___________
Hepatitis__________Rheumatic Fever__________Seizures__________Thyroid Disease____________
Venereal Disease__________HIV/AIDS__________Candida__________Other___________________

Exposure to environmental contaminants:__________________________________________
Habits: Cigarettes________Coffee________Tea_________Cola_______Alcohol______Drugs_______
Other_________________________________________________________________________

Family Medical History:
Cancer_________Diabetes__________High Blood Pressure___________Heart Disease___________
Stroke__________Seizures__________Asthma__________Allergies_________Alcoholism_________
Other_________________________________________________________________________

Physicians:____________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Acupuncture Consent Form: I hereby voluntarily agree to accept acupuncture treatments, and I am aware of the possible responses, such as bruising at the sight of needle insertion, that may occur as a result of this procedure. I also understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Signature:__________________________________________Date:______________