Annie Osborn, L.Ac., Dipl.Ac.

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Name:_____ Marital Status: _____ Number of Children: ____
Address: _____ Height: ____ Weight: ____ Birthdate: _____
City: _____ Occupation: _____
State: _____ ZIP: _____ Employer: _____
Cell Phone: (___)_____ Other Phone: (___)_____
Email: _____ Referred by: _____

Principal Concern: Check the primary areas of pain, discomfort or disorder.

Head____	Eyes____	Ears____	Nose____	Mouth____	Throat____
Heart____	Lungs____	Stomach____	Abdomen___	Bladder____	Lymph____
Neck____	Shoulder____	Arms____	Wrists____	Hands____	Fingers____
Fingernails___	Back____	Hips____	Legs____	Knees____	Calves____
Ankles____	Feet____	Toes____	Toenails____	Skin____	Weight____
Mentals____	Emotions___	Stress____	Nerves____	Memory____	Sleep____

Female Concerns: Check the primary areas of pain, discomfort or disorder.

Regularity___	Menses___	Preperiod___	Midcycle____	Postperiod___	Breast____
Vaginal____	Uterus____	Ovaries____	Desire____	Menopause____	

Are you now or have you ever taken the Birth Control Pill? ____ If so, for how long? _____

History: Check any of the following conditions you presently have or have had.

Anemia____	Alcohol____	Allergies____	Asthma____	Arthritis____	Bronchitis____
Blood Pressure_____		Candidiasis__	Cholesterol__	Colitis____	Cancer____
Colds____	Diabetes____	Dysentery___	Drug Abuse__	Epilepsy____	Flu____
Giardia____	Herpes____	Hypoglycemia_____		Hepatitis____	Malaria____
Pneumonia___	Parasites____	Prostate____	Polio____	Rheumatic fever____	
Strep____	Staph____	Skin disease__	Stones____	Thyroid____	Other_____

Generalities: Check any of the conditions you are presently experiencing.

Fatigue_____	Fever_____	Tremors____	Impotency___	Chills____	Sweats_____
Cravings____	Food intolerances_____		Thirst_____	Other_____	

Are you taking any medications? Please list: _____
_____

Are you taking any nutritional supplements? Please list: _____
_____