# Patient Intake Form

Margaret Stroz, MD

Medical Acupuncture
Classical Five Element Acupuncture

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Name: _____ Date: _____

Street:_____City: _____ State: ____ Zip: _____

Age: _____ Birth Date: _____ Occupation: _____

Phone: _____ Cell: _____ Email: _____

Physician: _____

Referred by: _____

Main Problem: _____

_____

Onset: _____

Other Concurrent Therapies: _____

_____

Medications: _____

_____

Allergies: _____

Past Surgeries: _____

Other Medical Problems: _____

_____

_____

_____

_____