Patient Intake Form

Margaret Stroz, MD

Medical Acupuncture
Classical Five Element Acupuncture

Name: Date:

Street: City: State: Zip:

Age: Birth Date: Sex:

Occupation: Phone: Cell:

Physician: Referred By:

Main Problem:

Onset:

Other Concurrent Therapies:

Medications:

Allergies:

Past Surgeries:

Other Medical Problems: