WHOLE PERSON HEALING

Dr. Deanine Picciano AP, LMT

Date: _____

Name: _____ Birthday:_____

Address:_____ City:_____

State:_____ Zip Code:_____

Phone Numbers: H:_____C:_____W:_____

Email:_____ Would you like to be on our list?: y n

Emergency Contact & Phone #:_____

Do you have Insurance: __Yes __No

Does it cover Acupuncture or Massage:__Yes__No __ please check

Whom can I thank for referring you?:_____

When is the last time you had any basic blood work done?:

__6 months __1 year ago __2 years ago __a long time __ never

Do you have a primary care physician? y/n

If so who:_____ Approx date last seen:_____

What do you want to work on? List up to 5 concerns.

What significant illnesses are in your family- mom, dad grandparents?

What significant illnesses, surgeries or injuries or traumas have you experienced?

Do you have a pacemaker, metal screws, plates or implants in your body? __ Yes __ No

Do you bruise easily? y/n Do you have Hepatitis/HIV? y/n

Are you pregnant? y/n If so how far along are you?: _____

Have you had Acupuncture before? y/n Have you had Massage y/n

What is your Blood Type: O A B AB No Idea

Circle best that describes your diet:

Omnivore Vegetarian Macrobiotic Raw No special diet Gluten Free

List supplements/Herbs/medications you currently take on the back:

On the back, list your average daily diet: