core healing llc
ryan marshall
M.A.T.C.M., Dipl.A.c, L.A.c

New Patient Intake

Your First Initial and Last Name

Today's Date

Please insure we have a copy of your insurance ID card on file today

Current Age: Birth Date: / / Height: Weight: Sex:

Address: City: State: Zip:

Primary Phone: Cell Phone/Carrier: Email Address: Social Security Number:

Is today's visit due to an injury? No Yes ☐ At Work ☐ Vehicle Accident ☐ Other:

Name of Emergency Contact: Relationship: Contact's Phone:

Name of Primary Physician: Physician's Phone:

Please list any other providers you've seen for your condition:

Have you ever seen an acupuncturist before? If so, who, when? No Yes

☐ Full Time ☐ Part Time ☐ Self-employed
☐ Retired ☐ Unemployed ☐ Student

How Did You Hear About Us?

Your Occupation: Employer:

What is your main health complaint today?

How long have you had this health concern?

Have you received a diagnosis for this issue?

For Office Use Only

Name of Insurance Representative:		
Policy Start Date:	Policy Deductible:	Policy Co-Pay Amount:
Date Deductible Met:	# of Visits Covered:	Office Visit Covered: