Patient Intake Form

Patient Name _____

Date_____/_____/_____ Time in_____(AM/PM) Time out_____(AM/PM)

Chief Complaints:

Current Assessment & Related Histories:

Pulse:

Tongue:

Vital Signs: BP T P R Others

TCM Disease Diagnosis:

Differentiation(s):

Treatment Principles:

Points & Methods:

Herbs & Instructions:

# of refills: Expiration Date:

# of needles used: # of needles disposed:

ICD-9 Code: CPT Code:

Comments:

Practitioner : (Print name) (Signature)

Kenneth C Greep L.Ac. 4131 Spicewood Springs Rd., Suite N8 Austin, TX 78757
Phone: 210-880-4372 Email: kcglac@gmail.com Web: www.kcglac.com