



Patient Information

CONFIDENTIAL

Eastern Harmony Acupuncture & Herbal Clinic ■ 4611 Montrose Blvd, Suite A201 ■ Houston, TX 77006
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Welcome to Eastern Harmony Acupuncture & Herbal Clinic

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Eastern Harmony Clinic considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST, MIDDLE)			DATE
AGE	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
PHONE (HOME)	PHONE (CELL)	PHONE (WORK)	
HOME ADDRESS			
CITY		STATE	ZIP
OCCUPATION		EMAIL ADDRESS	
EMPLOYED BY			
EMPLOYERS ADDRESS			
CITY		STATE	ZIP
REFERRED BY			
SPOUSE'S NAME			
CONTACT IN CASE OF AN EMERGENCY		RELATIONSHIP	PHONE
ADDITIONAL INFORMATION/NOTES			

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Eastern Harmony Clinic is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

SIGNATURE

DATE