Heritage
ACUPUNCTURE & WELLNESS

Intake Form for Return Patients

Name: Date:

Have you been exposed to COVID-19 or do you believe that you have? YES NO

Have you traveled to or from a high risk area in the past 14 days? YES NO

Please check any of the following symptoms that you are experiencing:

- shortness of breath
- productive cough
- non-productive cough
- bronchitis
- respiratory infection
- sore throat
- fever
- nausea
- vomiting
- diarrhea
- severe fatigue

Other: None of the above

What would you like to address during our session today? Please give details, including where you feel pain and whether there's numbness and tingling involved:

Rescheduling: Please provide options for your next appointment:

Requested date/time:

Requested date/time:

Payment: (Does not apply to VA patients or those insurance patients with no co-pay.) Please provide your credit card information for this visit's charges below. Please check here if we may store this card information:

Credit card number:

Expiration date:

Three-digit code:

By signing here, you attest that everything you stated above is truthful to the best of your knowledge:

Thank you and enjoy your session!