

**Fort Lee Health Center  
John Jun Mo Kim, L.Ac.  
1067 Palisades Ave  
Fort Lee, NJ 07024**

*This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions or concerns, please ask. Thank you.*

**Personal Information:**

Name: \_\_\_\_\_ Sex: M F

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Work/ Cell Phone: \_\_\_\_\_

Cell Phone Carrier: \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you?: \_\_\_\_\_

Have you received Acupuncture before? Yes No

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**Medical History:**

*Please mark an 'X' if you currently have any of the following significant illnesses have:*

Cancer: \_\_\_\_\_ Hepatitis: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Seizures: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_ Heart Disease: \_\_\_\_\_ Tuberculosis: \_\_\_\_\_

Rheumatic Fever: \_\_\_\_\_ Emotional Disorder: \_\_\_\_\_

Other (Please list): \_\_\_\_\_

Infectious Diseases: \_\_\_\_\_ (if 'yes' please indicate specifically): \_\_\_\_\_

Have you ever had any blood infections such as HIV or any Hepatitis infections? \_\_\_\_\_

If 'yes' please indicate specifically: \_\_\_\_\_

**Please indicate any medications or supplements you are taking along with its dosage:**

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**Please indicate any past medical procedures (i.e. surgeries) or any accidents you have been involved. Also please list the times such as the year (i.e. Left foot surgery, 20XX):**

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**Please indicate any allergies you may have:**

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**What are the main health problems for which you are seeking treatment?**

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