Licensed Marriage & Family Therapist, EMDR & TRM Certified, PACT Trained
C. Nathan Bergeron, LMFT (MFC 50298), L.Ac. (AC 8941)
Voice Dialogue Facilitator & Teacher, Licensed Acupuncturist & Herbalist

C. Nathan Bergeron, LMFT, L.Ac.
1913 N. Las Palmas Ave.
Hollywood, CA 90068

email: nathan@cnathanbergeron.com
h/o: 323.850.6508
c: 323.377.7794
fax: 323.850.6548

ACUPUNCTURE INTAKE

Date:___________

First name:___________________________ Mi:_____ Last name:____________________________
Address:_______________________________ City:____________________ State:___ Zip:__________
Home:(____)________________ Work :(____)________________ Cell:(____)____________________
SSN:______________ DOB:_________Age_____ Sex:___ Ht:_____ Weight:____ Ethnicity:___________
Email: ____

❍ Minor, ❍ Single, ❍ Dating, ❍ In partnership, ❍ Married, ❍ Separated, ❍ Divorce, ❍ Widow

Occupation:______________________________ Employer:_____________________________________
Work Address:_____________________________ City:__________________ State:____ Zip:_________
Emergency contact:____________________________ Relation:__________ Tel# (___)_______________
Referral Source ____ OK to thank him/her? ❍ Yes ❍ No
(If yes, only the fact that you came to acupuncture will be acknowledged, NOTHING about the content of your diagnosis and treatment will ever/never be discussed or shared with anyone without your written consent.
Primary Care physician:___________________________________ Tel:(____)_____________________
Address:___________________________________ City:________________ State:___ Zip:__________

Past & Present Medical History: Use ❍ for past symptoms, ❏ for current symptoms.

❍ ❏ Alcohol________/day-wk	❍ ❏ Cold sores/ Herpes	❍ ❏ Herniated disc	❍ ❏ Respiratory issues
❍ ❏ Allergies	❍ ❏ Coffee-Soda__/day-wk	❍ ❏ High cholesterol	❍ ❏ Rheumatoid arthritis
❍ ❏ Anemia	❍ ❏ Diabetes	❍ ❏ High blood pressure	❍ ❏ Seizures
❍ ❏ Anorexia/ Bulimia	❍ ❏ Digestion	❍ ❏ Hormonal dysfunction(s)	❍ ❏ Sexual infections/ STD's
❍ ❏ Appendicitis	❍ ❏ Drug-Toxin poisoning	❍ ❏ Kidney dysfunction(s)	___________________________
❍ ❏ Asthma	❍ ❏ Epilepsy	❍ ❏ Liver dysfunction(s)	❍ ❏ Skin dysfunctions
❍ ❏ Bleeding disorders	❍ ❏ Fatigue	❍ ❏ Low blood pressure	❍ ❏ Smoking________/day-wk
❍ ❏ Birth trauma	❍ ❏ Fracture(s)	❍ ❏ Mental/emotional stress	❍ ❏ Stroke
❍ ❏ Breast Issues	❍ ❏ Gall stone(s)	❍ ❏ Miscarriage	❍ ❏ Traumatic injuries
❍ ❏ Bulimia	❍ ❏ Gout	❍ ❏ Numbness	❍ ❏ Ulcers__________________
❍ ❏ Cancer______________	❍ ❏ Headache	❍ ❏ Osteoporosis	❍ ❏ Urinary Dysfunction(s)
❍ ❏ Chemical dependency	❍ ❏ Heart dysfunctions(s	❍ ❏ Pacemaker	❍ ❏ Viral Infection(s)
❍ ❏ Chest congestion	❍ ❏ Hemorrhoids	❍ ❏ Parkinson disease	❍ ❏ Visual dysfunction(s)

❍ ❏ Explain / Other ____

Vitamins, Minerals, Supplements: ____
____

Medication(s) taken & why: ____
____

Chief complaint/ Reason(s) for consultation: ____
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____