Marissa Loya DOM, LMT
1418 Luisa St 4A
Santa Fe, NM 87505

Acupuncture and Massage Intake Form

Date: ________________

Patient Name: _____________________________________ Phone#__________________________

Date of Birth: _________________ Address:____

City: __________________________________ State: __________________Zip:_____________________

Email Address:____

In an Emergency please Notify: ______________________________ Phone # ____________________

Have you received acupuncture and/or massage before? YES NO

Main Complaint: ____

How long have you had the problem? ____

Do you have a Western Medical Diagnosis for the problem? ___________________________________

Does it affect your daily living? ________________________________

What improves the condition? ____

Any other conditions we should know of, such as bleeding disorders?

Please List Medications used with associated conditions:

Please list surgeries (continue on back if needed):

PRINT NAME:

Please indicate any painful areas by circling the particular area on the body:

Pain scale for areas marked: 0-10 (10 being most painful)