

CHINA HEALTH CENTER, INC.

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Phone Consultation Form

This is a confidential questionnaire. The information you provide will help us determine the best treatment plan for you. If you have any questions, please ask us. Thank you.

Consultation: Date: _____ **Time:** _____ **Phone** _____

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Office Phone _____

Cell Phone: _____ Height _____ Weight _____

Occupation: _____

Sex: Male _____ Female _____ Age: _____ Marital Status: _____

Medications (Recent): _____

Habits: Coffee _____ Tea _____ Tobacco _____ Other _____

Women: Menstrual Cycle: Regular _____ Irregular _____ Other _____

Description of current complaint and general symptoms:

CC#: _____ Exp Date _____