ACUJIN HOLISTIC THERAPIES
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4. List ALL Medications (prescription & over-the-counter) you are CURRENTLY taking (include duration of use & dosage):

5. List ALL Allergies (Food, Medications, Pollen, etc):

6. List ALL Medical Conditions of your immediate family(mother, father, siblings):

Habits: Please mark any of the habits listed below which apply to you.

Smoking: ❑ Yes ❑ No	If Yes, # cigarettes per day:	How long?
Alcohol: ❑ Yes ❑ No	If Yes, # drinks per week:	Age started?
Caffeine: ❑ Yes ❑ No	If Yes, # sodas/coffee/tea per day:	
How much water do you drink?		