PURE JOY ACUPUNCTURE
Replacing pain, stress & anxiety with joy

Patient Information

Today's date: _____

Name: _____Birth date: _____Age: _____

Preferred name: _____ Gender: _____

Occupation: _____Employer: _____

Email address:_____

Would you like to receive our seasonal e-mail newsletter? _____

Phone:_____

Mailing address:_____

Would you like to receive a holiday card? _____

Emergency contact:

Name: _____Phone: _____Relationship: _____

How did you hear about our clinic: _____

May we send a thank you card to the person who referred you? Yes No

Cancelation Policy:

If you need to change or cancel your appointment, please do so with a minimum of 24 hours notice. Failure to do so will result in being charged the full fee of your missed appointment.

☐ I understand the cancelation policy

Signature _____ Date _____

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Have you ever been treated with acupuncture? Yes No

If yes, condition treated? _____

Primary reason for your visit: _____

Additional health concerns:

_____

Major hospitalizations, surgeries, illnesses, injuries:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current medications that you are taking:

Start date:	Item:	Dosage:	What does this medication treat?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any known allergies:

_____

Please list all current vitamins, supplements and herbs that you are taking:

Start date:	Item:	Brand:	Dosage:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____