New Patient Information

Name: Today's Date:

Date of Birth: Place of Birth: Age:

Address: Zip:

Phone: Email:

It is OK to leave a message at this number about appointment times (initial here please) X

If you do NOT wish to receive emails, please indicate here…

Please circle your Marital Status: Single Married Divorced Life Partner Widow/er

Date of last check up: Primary Doctor:

Main Reason for seeking Acupuncture:

Have you ever had Acupuncture before? If yes, When?

Are you nervous about getting Acupuncture?

Do you or your immediate family have any of the following (mark all that apply)

Me: Family:

AIDS/HIV

Hepatitis

Herpes

Heart Disease

Pace Maker

Diabetes

Panic or Seizures

Lung Disease

Chronic Depression

Other (please list)

Emergency Contact: Number:

How did you hear about me??

All of the above information is true & current X