Gloyeske Acupuncture Pointe

New Patient Forms

Name____ Date_____________

D.O.B. ________________________________

Address_______________________________________ City_______________

State _________ Zip______________

Email______________________________________ Phone_______________

Emergency Contact Name and
Number____

Relationship to Contact____

Have you had acupuncture before? Yes_________ No_________

Are you or may you be pregnant? Yes_________ No_________

Do you have Hepatitis B or C or have you ever been diagnosed with AIDS/HIV?
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What would you like to be addressed with your treatments? Please specify.
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Occupation? ____

What improves and worsens your condition?
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Please list your current medications, supplements, and nutritional therapies and the reason for using them.
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Do you have any allergies? If so, please list.

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Do you have any skin conditions? If so, please list.

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Please list any major illnesses, injuries, accidents, or surgeries you have had.

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Are you currently under a physician's care for an acute or chronic illness? If so, please describe.

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What kinds of things are important to you in your life?

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