Pure Health ACUPUNCTURE LLC
A Natural Healing and Wellness Center

Patient Information

_____ / /
Last Name **First** **MI** **Date of Birth**

_____
Primary Phone **E mail Address**

May we leave medical related messages on this voicemail? (Circle one)
YES / NO Initial: _____

May we send medical related messages to this email? (Circle one)
YES / NO Initial: _____

_____
Address **City** **State** **Zip Code**

_____
Emergency Contact (Name) **Contact Phone**

Allergies _____
(*Please list all allergies*) _____
_____
_____

Previous Illness / Injury _____
***(Please date*)** _____
_____

Current Medication / Herb / Supplement List _____
(*use additional sheet if needed*) _____
_____
_____
_____

How did you find out about us? _____

Patient Signature: _____ **Date:** _____