Acupuncture Center

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's First Name:	Last:	Middle:			Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:					Home phone no.: ( )
City:	State:	ZIP Code:			Cell phone no.: ( )
Occupation:	Employer:				Work phone no.: ( )
Employer's Address:					Personal E-mail:
Referred by:					Social Security no.:
					Driver's License:
Appointment Reminder by: ❑ Phone Call ❑ Email ❑ Text Message					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of Primary Insurance:	Policy no.:	Group no.:		Insurance phone no.: ( )
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child	❑ Other	
Name of Secondary Insurance:	Policy no.:	Group no.:		Insurance phone no.: ( )
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child	❑ Other	

EMERGENCY CONTACT INFORMATION

Name of local friend or relative:		Relationship to patient:
Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the health provider. I understand that I am financially reponsible for any balance. I also authorize Acupuncture Center or insurance company to release any information required to process my claims.

Patient's Signature (Parent/Guardian signature if patient is a minor) Date

❑ Check box if you would like to be put on the Acupuncture Center email list to receive office updates and upcoming newsletters.

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CASE HISTORY

(Please Print)

PATIENT INFORMATION

Main Complaint: (Please indicate when it started, diagnosis, symptoms and any other information you would like me to know.)

Have you seen any other doctor about this condition? ❑ Yes ❑ No	If yes, when?	Physician's name:

Other Complaint(s): (Please indicate when it started, diagnosis, symptoms and any other information you would like me to know.)

Have you seen any other doctor about this condition? ❑ Yes ❑ No	If yes, when?	Physician's name:

PHYSICIAN INFORMATION

Primary Physician's name:		Phone no.: ( )	Date of last physical: / /
Street address:	City:	State:	ZIP Code:
Other treating medical professional's name:	Type/Specialty:	Phone no.: ( )	Date of last exam: / /
Other treating medical professional's name:	Type/Specialty:	Phone no.: ( )	Date of last exam: / /
Other treating medical professional's name:	Type/Specialty:	Phone no.: ( )	Date of last exam: / /

Have you had acupuncture before? ❑ Yes ❑ No	If yes, for what condition?

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HEALTH HISTORY

(Please Print)

PATIENT INFORMATION

Significant Trauma: (physical or emotional)

Hospitalizations & Surgeries: (Date/Description/Place)

Medications: (Name/Dosage/Indicated for)

Vitamins/Supplements/Herbs: (Name/Dosage/Indicated for)

Allergies: (chemical, environmental, food, drugs, etc.)

Mark any that apply to you:

	❑ Pacemaker	❑ Electric Implants	❑ Metal Implants	❑ Severe Bleeding Disorders
❑ Pregnant	❑ Cancer	❑ Thyroid Imbalance	❑ Diabetes	❑ Hepatitis
❑ Stroke	❑ Heart Disease	❑ Low Blood Pressure	❑ High Blood Pressure	❑ HIV

FAMILY MEDICAL HISTORY

Complete for each family member. Place an X in the box indicating any illnesses they ever had.

	Self	Mother	Mother's Family	Father	Father's Family	Siblings
Allergies						
Anemia/Blood Dis						
Arthritis						
Asthma						
Cancer or Tumors						
Type						
Chemical Dependency						
Diabetes						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney/Bladder Dis						
Mental Illness						
Migrains						
Seizures/Epilepsy						
Stomach/Intestinal Dis						
Stroke						
Thyroid Dis						
Tuberculosis						
Other						
Specify						
		Age:		Age:		Age:

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HEALTH HISTORY

(Please Print)

LIFESTYLE & DIET

Type of Diet: ❑ Standard American ❑ Low Fat ❑ Weight Loss ❑ Vegan ❑ Other (specify)

❑ Fast/Quick Prep ❑ Balanced Food Groups ❑ Low Carb ❑ Muscle Building ❑ Vegetarian

Meals:			Avg Time of Day	Description of Meal
Breakfast	❑ Yes	❑ No		
Snack	❑ Yes	❑ No		
Lunch	❑ Yes	❑ No		
Snack	❑ Yes	❑ No		
Dinner	❑ Yes	❑ No		
Snack	❑ Yes	❑ No		

			When Started	When Stopped	Amount (quantity, # of days, days per week)
Coffee	❑ Yes	❑ No			
Tea	❑ Yes	❑ No			
Soda	❑ Yes	❑ No			
Alcohol	❑ Yes	❑ No			
Tobacco	❑ Yes	❑ No			
Illegal Drugs	❑ Yes	❑ No			
Other	❑ Yes	❑ No			

Have you ever had an eating disorder? ❑ Yes ❑ No

Type: _____

Is Nutrition something you would like to improve? ❑ Yes ❑ No

Activity Level: (Mark the one that best applies to you.)

❑ Sedentary Job w/ No Exercise ❑ Moderate Job w/ No Exercise ❑ Active Job w/ No Exercise

❑ Sedentary Job w/ Some Exercise ❑ Moderate Job w/ Some Exercise ❑ Active Job w/ Some Exercise

❑ Sedentary Job w/ Much Exercise ❑ Moderate Job w/ Much Exercise ❑ Active Job w/ Much Exercise

Exercise:

Type of Activity	Length of time	Days per week

Would you like to improve or add to your exercise regimen? ❑ Yes ❑ No

Mood: (Do you experience any of the following often?)

❑ Depression ❑ Isolated ❑ Grief ❑ Irritable ❑ Anxiety ❑ Fear ❑ Nervousness

❑ Sadness ❑ Hopelessness ❑ Anger ❑ Mood Swings ❑ Insecurity ❑ Phobias ❑ Obsessive Thinking

Would you like to improve your mood? ❑ Yes ❑ No

Which of the following areas of life are you satisfied?

❑ Work ❑ Relationship ❑ Friends ❑ Family ❑ Spiritual Life ❑ Health ❑ Security

Sleep: (Average Time of Day) Go to Bed: _____ Wake Up: _____ Insomnia? ❑ Yes ❑ No

Would you like to improve your sleep quality? ❑ Yes ❑ No

Stress Level: ❑ High Stress ❑ Moderate Stress ❑ Mild Stress ❑ Periodic Stress ❑ Not Stressed

Would you like to handle stress better, or reduce the effects of stress? ❑ Yes ❑ No

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HEALTH HISTORY

(Please Check any that pertain to you)

SKIN & HAIR

❑ Dry Skin ❑ Nail problems ❑ Eczema ❑ Psoriasis ❑ Acne ❑ Recent moles ❑ Change in moles
❑ Itching ❑ Dandruff ❑ Hives ❑ Fungal infection ❑ Warts ❑ Skin discoloration ❑ Change in skin
❑ Rashes ❑ Loss of Hair ❑ Athlete's Foot ❑ Corns ❑ Open Sore ❑ Change in hair

HEAD, EYES, EARS, NOSE and THROAT

❑ Headache ❑ Dental problems ❑ Poor vision ❑ Cataracts ❑ Sinus problems ❑ Sore Throat
❑ Migraines ❑ Gum problems ❑ Eye Strain ❑ Glaucoma ❑ Nasal Congestion ❑ Hoarse Voice
❑ Concussion ❑ Mouth Sores ❑ Eye Pain ❑ Night Blindness ❑ Nose Bleeds ❑ Difficulty Swallowing
❑ Dizziness/Vertigo ❑ Sores on Lips ❑ Blurry Vision ❑ Color Blindness ❑ Polyps ❑ Poor Hearing
❑ Facial Pain ❑ Sores on Tongue ❑ Floaters/Spots ❑ Glasses/Contacts ❑ Deviated Septum ❑ Ringing in Ears
❑ TMJ ❑ Grinding Teeth ❑ Sudden Vision Change ❑ Earache
❑ Jaw Clicks/Locks

RESPIRATORY (LU)

❑ Cough ❑ Phlegm ❑ Allergies ❑ Difficult Breathing ❑ Shortness of Breath ❑ Bronchitis
❑ Wheeze ❑ Tight Chest ❑ Sweat Easily ❑ Difficulty Inhaling ❑ Pain w/ Deep Breath ❑ Pneumonia
❑ Chills ❑ Asthma ❑ Catch Colds Frequently ❑ Difficulty Exhaling ❑ Emphysema
❑ Fever ❑ Coughing Blood ❑ Difficulty Breathing Lying Down ❑ Pleurisy

CARDIOVASCULAR (HT)

❑ Palpitations ❑ Insomnia ❑ Low Blood Pressure ❑ Coronary Heart Disease ❑ Miral Stenosis
❑ Chest Pain/Pressure ❑ Difficulty falling asleep ❑ High Blood Pressure ❑ Pheumatic Heart Disease ❑ Mitral Prolapse
❑ Irregular Heart Beat ❑ Difficulty staying asleep ❑ Cold Hands/Feet ❑ Hardening of Arteries ❑ Myocarditis
❑ Fainting ❑ Blood Clots ❑ Swelling of Hands/Feet ❑ Varicose/Spider Veins ❑ Phlebitis

GASTROINTESTINAL (SP/ST, LI, LIV)

❑ Low Appetite ❑ Change in Appetite ❑ High Appetite ❑ Constipation ❑ Hemorrhoids ❑ Colitis
❑ Fatigue ❑ Weigh Loss/Gain ❑ Strong Thirst ❑ Abdominal Pain ❑ Rectal Pain ❑ Crohn's Disease
❑ Bloating ❑ Bleed/Bruise Easily ❑ Nausea ❑ Acid Reflux/GERD ❑ Blood in Stool ❑ IBS
❑ Borborygmus ❑ Hernia ❑ Vomiting ❑ Belching ❑ Black/Tar Like Stools ❑ Rib Pain
❑ Gas ❑ Anemia ❑ Bad Breath ❑ Indigestion ❑ Chronic Laxative Use ❑ Jaundice
❑ Loose Stools ❑ Muscle Weakness ❑ Diarrhea ❑ Cravings ❑ Alternating Diarrhea & Constipation

GENITO-URINARY (KD/UB)

❑ Painful Urination ❑ Unable to Hold Urine ❑ Decreased Libido ❑ Genital Itching ❑ Premature Ejaculation
❑ Frequent Urination ❑ Weak Urine Stream ❑ Increased Libido ❑ Abnormal Discharge ❑ Nocturnal Emission
❑ Urgent Urination ❑ Dribbling After Urination ❑ Kidney Stones ❑ Yeast Infection ❑ Prostate Problems
❑ Burning Urination ❑ Bed Wetting ❑ Urinary Tract Infection ❑ Genital Sores ❑ Prostatitis
❑ Blood in Urine ❑ Night Urination ❑ Bladder Infection ❑ Herpes ❑ Testicular Pain
❑ Cloudy Urine ❑ Scanty Urine ❑ Kidney Infection ❑ Venereal Disease ❑ Impotence
❑ Lower Back Pain ❑ Excessive Urine ❑ Edema

NEUROPSYCHOLOGICAL

❑ Seizures ❑ Difficulty Concentrating ❑ Lack of Coordination ❑ Panic Attacks ❑ ADD/ADHD
❑ Tremors ❑ Poor Memory ❑ Loss of Balance ❑ Mood Swings ❑ Manic Depression
❑ Areas of Numbness ❑ Mood Disorder ❑ Seasonal Affective Disorder
Have you ever been treated for emotional problems? ❑ Yes ❑ No ❑ Alcoholism
Have you ever considered or attempted suicide? ❑ Yes ❑ No
Have you ever been treated for substance abuse? ❑ Yes ❑ No

INFECTION

❑ Measles ❑ Chicken Pox ❑ Malaria ❑ Rheumatic Fever ❑ Tuberculosis
❑ Mumps ❑ Small Pox ❑ Typhoid Fever ❑ Scarlet Fever ❑ Whooping Cough

OTHER

❑ Hot Flashes ❑ Night Sweats ❑ Osteoporosis

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HEALTH HISTORY

(Please Print)

GYNECOLOGICAL/REPRODUCTIVE

- ❑ Difficult/Painful Intercourse
- ❑ Vaginal Dryness
- ❑ Excess Vaginal Discharge
- ❑ Leukorrhea
- ❑ Painful Menstruation
- ❑ Menstrual Cramps
- ❑ Irregular Periods
- ❑ PMS
- ❑ Dark Menstrual Blood
- ❑ Light Menstrual Blood
- ❑ Excess Menstrual Blood
- ❑ Scanty Menstrual Blood
- ❑ Unusual Menstrual Blood
- ❑ Blood Clots
- ❑ Breast Lump(s)
- ❑ Fibrocystic Breasts
- ❑ Uterine Fibroids
- ❑ Ovarian Cysts
- ❑ Polycystic Ovarian Disease
- ❑ Endometriosis

_____ Number of Pregnancies

_____ Number of Ectopic Pregnancies

_____ Number of Births

_____ Number of Abortions

_____ Number of Miscarriages

_____ Age at 1st Menstruation

_____ Number of Days Between Periods

_____ Number of Days of Period

_____ First Day of Last Period

_____ Date of Last PAP/Pelvic

❑ Use of Birth Control

Type: _____

_____

How Long: _____

Previous Pregnancies:

Year	Length	Labor Hours	Type of Delivery	Complications