

NEW PATIENT REGISTRATION FORM



Name _____ M or F Date of Birth ____/____/____
First Middle Last mm dd yy

Address _____ Home Phone (____) _____

City _____ State _____ Zip Code _____ Cell Phone (____) _____

Occupation _____ E-mail _____

Height _____ Weight _____ Single _____ Married _____ Child _____ Other _____

Have you ever had acupuncture Yes or No Other family members currently patients _____

Referred by Dr. _____ Family member _____ Friend _____ Other _____

Emergency Contact

Name _____ Relationship _____ Cell Phone (____) _____

HEALTH INFORMATION

For the following questions, please check whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Have you ever had any of the following?

<input type="checkbox"/> Aids+/HIV	<input type="checkbox"/> Drug/alcohol Abuse	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Hyper Thyroid	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hypo Thyroid	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Faint	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Tumors
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker	Other _____

Please list the medicines, vitamins or herbs you are using

1. _____ Taking for _____ 3. _____ Taking for _____
2. _____ Taking for _____ 4. _____ Taking for _____

Please list the surgeries you had _____ / _____ year Allergies to _____

Please describe your main complaint _____

How long ago did this problem begin _____ Have you been given a diagnosis _____

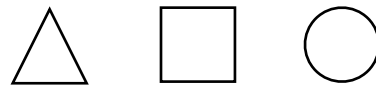
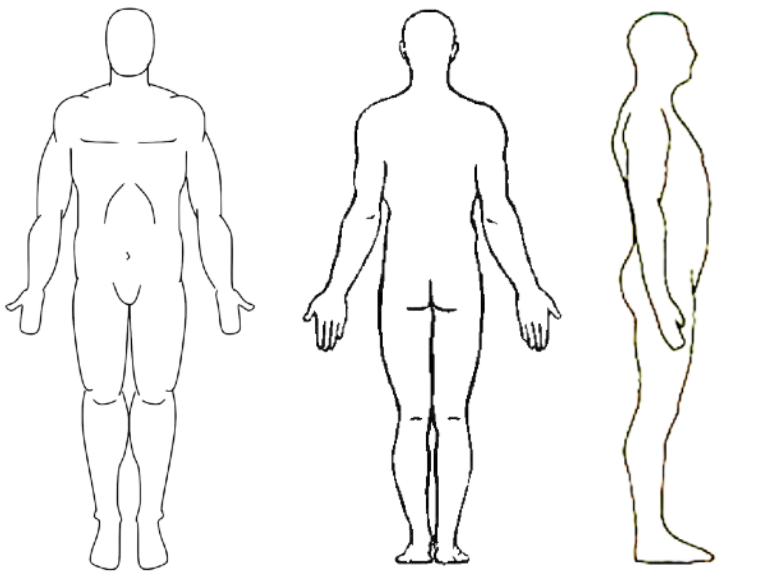
Current symptoms

___ Anxiety ___ Depression ___ Irritability ___ Fatigue ___ Insomnia ___ Chill/Fever ___ Blurred vision
___ Ear ringing ___ Day/Night sweating ___ Asthma ___ Dry mouth ___ Cough ___ Shortness of breath
___ Chest tightness ___ Irregular heartbeat ___ Palpitation ___ Acid reflex ___ Nausea ___ Food craving
___ Abdominal distention/cramps ___ Constipation ___ Diarrhea ___ Blood in urine ___ Urgent/Pain urination

Energy level ___ (Scale 0-10) **Stress level** ___ **Appetite** ___ Good or ___ Poor **Water** ___ mugs/day

Bowel movement ___ /day or ___ /week **Urination** ___ /day and ___ /night **Others** _____

Please CIRCLE on the diagram any areas of pain or injury



Current pain level of 1st point _____

Current pain level of 2nd point _____

Current pain level of 3rd point _____

(Scale of 0-10)

Describe the type and quality of the pain

___ Aching ___ Burning ___ Cramping
___ Dull ___ Shooting ___ Stabbing
___ Throbbing ___ Radiating ___ Fixed
___ Constant ___ Muscular weakness
___ Numbness ___ Tingling ___ Spasms

Aggravating factors ___ Sitting ___ Lifting ___ Bending forward ___ Cold ___ Weather change **Other** _____

Relieving factors ___ Rest ___ Exercise ___ Cold ___ Heat **Other** _____

Females **Age at First Menses** ___ **Length of cycle** ___ days **Duration of flow** ___ days of bleeding

___ Heavy ___ Light ___ Clots ___ Painful period ___ Irregular period ___ Breast lumps

Date of last Pap Smear _____ **Date of last Mammogram** _____ **Profuse Leukorrhea** _____

Yellowish Leukorrhea _____ **Are you pregnant** ___ **Yes or No** If yes, expected due date _____

Number of Pregnant ___ **Number of Births** ___ **Miscarriages** ___ **Abortions** ___ **Age at Menopause** _____

Signature _____

Date ___ / ___ / ___