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?

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

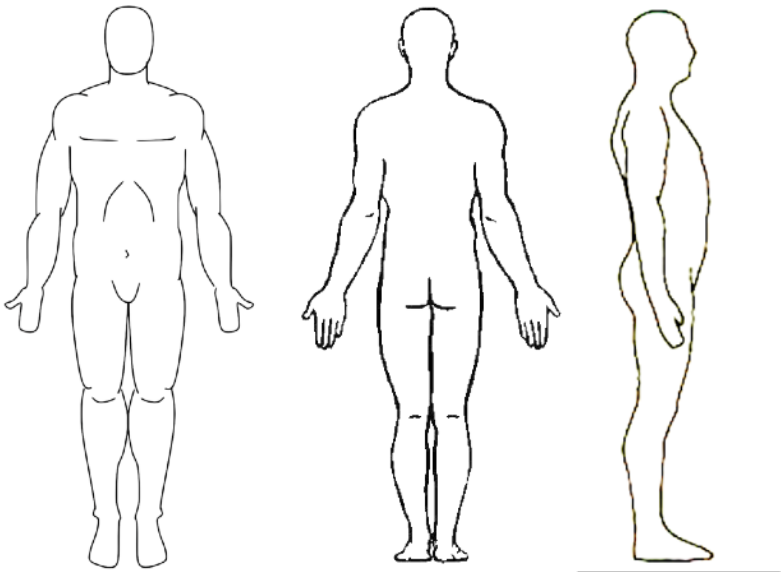
How long ago did this problem begin _____ Have you been given a diagnosis _____

Current symptoms

___Anxiety/Depression ___Irritability ___Chill/Fever ___Vertigo ___Blurred vision ___Ear ringing
___Day/Night sweating ___Insomnia ___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** _____/_____/_____