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.___________ Friend____________ Facebook Google Postcard Yelp 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	___ Dizziness	___ High Blood Pressure	___ Respiratory Problems
___ Anemia	___ Drug/alcohol Abuse	___ High Cholesterol	___ Rheumatism
___ Arthritis	___ Epilepsy/Seizures	___ Hypo/Hyper Thyroid	___ Sinus Problems
___ Artificial Joints	___ Excessive Bleeding	___ Jaundice	___ Stomach Problems
___ Asthma	___ Faint	___ Kidney Disease	___ Stroke
___ Blood Disease	___ Glaucoma	___ Liver Disease	___ Tuberculosis
___ Blood Transfusion	___ Hay Fever	___ Low Blood Pressure	___ Tumors
___ Cancer	___ Head Injuries	___ Mental Disorders	___ Ulcers
___ Cardiovascular Disease	___ Heart Disease	___ Nervous Disorders	___ Venereal Disease
___ Diabetes	___ Hepatitis	___ Pacemaker	Other_________________

Please list the medicines, vitamins or herbs you are using

1.________________ Taking for ________________ 2.________________ Taking for ________________

3.________________ Taking for ________________ 4.________________ Taking for ________________

Please list the surgeries you had _____________________/______ year **Allergies to** __________________

Please describe your main complaint ____

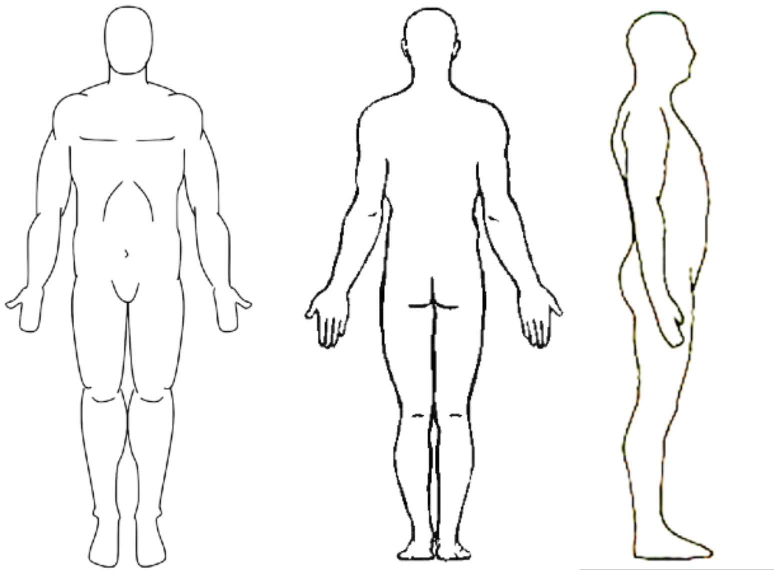
How long ago did this problem begin _____________ Have you been given a diagnosis _______________

Current symptoms

___Anxiety ___Depression ___Fatigue ___Shortness of breath ___Insomnia ___Cough ___Asthma
___Day sweating __Night sweating ___Palpitation ___Irregular heartbeat __High Cholesterol ___Nausea
___Acid reflex ___Abdominal pain/cramps ___Constipation ___Diarrhea ___Urgent urination
___Pain on urination ___Blood in urine ___Wake up to urinate ___Arthritis ___Muscular weakness
___Area of numbness ___Spasms

Energy level____(Scale 0-10) **Stress level**_____ **Appetite**___Good or ___Poor **Water**____mugs/day
Coffee____cups/day **Bowel movement**___/day or ___/week **Urination**___/day 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

___Burning ___Cramping ___Knife like
___Dull ___Throbbing ___Moving radiating
___Fixed ___Constant

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** ______/______/___________