Patient Registration Form

CONFIDENTIAL

Name: ____ Date:__________________

Age:______ Date of Birth:_____________ Sex:_____M________F_______

Marital Status:____Single____Married____Partnered_____Separated_____Divorced_____Widowed______

Spouse/Partner's Name:____

Home Address:____City:_____________________

State:_____ Zip Code:____________E-mail Address:__________________________________

Home Phone:(_____)______________________ Cell Phone: (_____)_____________________

Employer:____________________________Occupation:______________________________

Emergency contact:__________________________ Phone: (_____)______________________

Relation:____

Medical Insurance Carrier:__________________________Policy #:______________________

Name of your Medical Doctor:____

How did you hear about our clinic?____

Who may we thank for referring you?____

Health History Form

CONFIDENTIAL

Patient Name:______________________________________ Date:______________________

Please describe your chief complaint:

____

____

____

____

____

	Mild				Moderate					Severe
Severity of your complaint:	1	2	3	4	5	6	7	8	9	10

When did you first experience these symptoms?______________________________________

Was there any trauma relating to the onset of your complaint, and if so please describe?_________

____

____

Describe how your complaint affects your daily activities:_______________________________

____

What have you done to address this complaint:_______________________________________

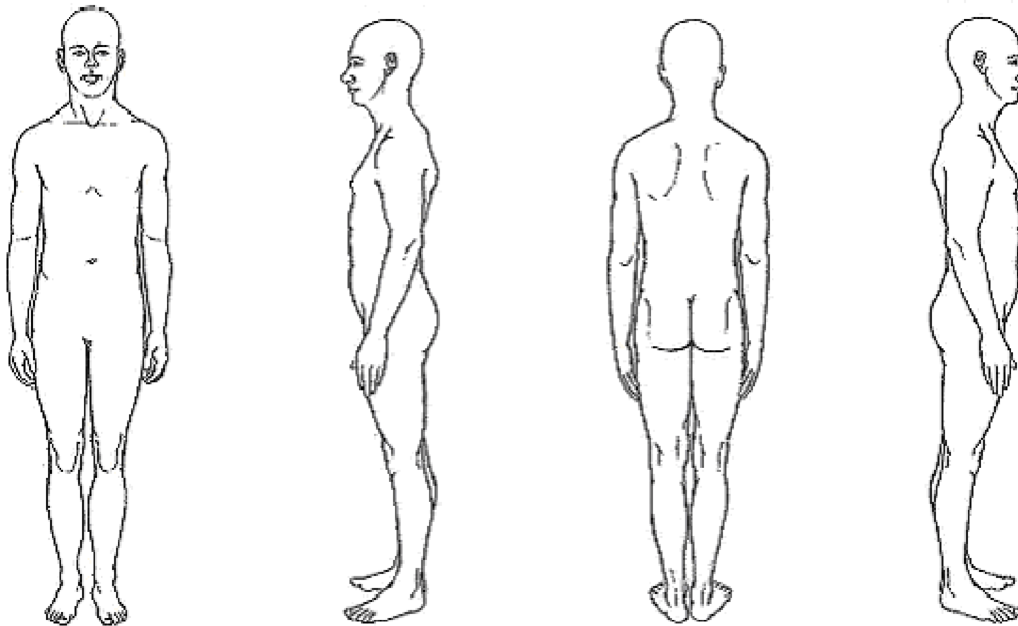
____

____

Describe any lab work or imaging you have had done (if any):____________________________

____

Please mark any areas of pain with an "X", and any major scars with "S"



Select the quality of the pain:

___Sharp ______Burning ______Cramping ______Tingly
___Dull ______Aching ______Numb

Which of the following alleviate the pain?

___Heat _____Exercise _____Rest _____Dry/hot clclimate _____Damp/ cold clclimate
___Cold _____Activity _____Pressure

Which of the following aggravate the pain?

___Heat _____Exercise _____Rest _____Dry/hot clclimate _____Damp/ cold clclimate
___Cold _____Activity _____Pressure

Is the pain constant? __Y___N___

If no, what time of the day does the pain occur:

___Morning _____Afternoon _____Evening _____Night

Does the pain affect your sleep? __Y___N___

Does the pain radiate? __Y___N___

Other comments regarding your pain:____

____

Women Only:

Pregnant? __Y___N___ If yes, due date:_____ Number of children:____
Are you trying to get pregnant? __Y___N___
Number of pregnancies: _____
Regular Menstrual cycle? __Y___N__ Average number of days of bleeding:____
Average number of days of entire cycle:____
Vaginal discharge? ___Y___N___ Bleeding between periods? ___Y___N___

If applicable, please check the following pre-menstrual symptoms you experience:

___Dull cramping ___Bloating ___Water retention
___Sharp cramping ___Migraines ___Irritability
___Low back pain ___Headaches ___Depression
___Breast tenderness ___Hunger/cravings ___Nausea
___Breast swelling ___Low appetite ___Vomiting

If applicable, please check the following menopausal symptoms you experience:

___Hot flashes ___Vaginal dryness ___Sleep disturbance
___Increased abdominal fat ___Mood swings ___Thinning hair

Other____

Men Only:

___Benign prostate hyperplasia (BPH) ___Erectile dysfunction
___Urinary difficulty ___Testicular pain
___Urinary pain ___Cold sensation of external genitalia
___Spermatorrhea

Please list any other conditions or concerns regarding your health: ___________________________

____

____

Current Medications (if any):____

____

Dietary Supplements (herbs, vitamins, minerals, etc):______________________________________

____

Please list your medical history including past conditions, surgeries, etc:_____________________

____

____

Please list your family medical history:____

____

____

The following is a list of some of the many conditions acupuncture affectively treats. Please select any of the following conditions if you would like more information on how we may be able to help.

___IBS
___Acid reflux
___Nausea/vomiting
___Infertility
___Ovarian cysts
___Hot flashes
___Anxiety
___Depression
___Insomnia
___Fatigue
___Stress
___Asthma
___Arthritis
___Tendonitis
___Sciatica
___Carpal tunnel
___Fibromyalgia
___Common cold
___Flu
___Immune weakness
___Shingles
___Bell's Palsy
___Thyroid disorders
___Stroke rehabilitation
___Bladder infection
___Interstitial cystitis
___Low libido
___Vertigo
___Anemia
___Gout
___Migraines
___Headaches
___Trigeminal neuralgia
___Allergies
___Sinus infections
___Addiction

Other comments or questions:

____

____

____

Please sign and date:

Patient Signature:____________________________________ Date:_____________________

Acupuncturist Signature:______________________________ Date:_____________________