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NEW PATIENT REGISTRATION

Patient Name ____ Birthdate :_______________ Age: ________

Address ____ Gender ______Female ______Male

City, State, Zip ____ Marital Status Single Married Separated Divorced Widowed

Occupation ____ Employer ____

Your Phone # (_____)____________________________ (_____)________________ ________________________________
Home OK to call you there? Y N Cell Email

Emergency Contact____(_____)_______________
Name Relationship to Patient Phone #

Primary Care Physician ____

Primary Insurance Information
Secondary Insurance Information (if applicable)

(a copy of the insurance card will be sufficient provided you fill out insured's information if different from the patient's information)

Insured Name ____ Insured Name ____

Insured Birthday _____________________________________ Insured Birthday ____

Employer ____ Employer ____

Patient's Relationship To the insured _____ Self ____Spouse ____ Dependent

Patient's Relationship to the insured _____ Self _____Spouse _____Dependent

Present health concerns in order of importance to you (include diagnosis if applicable): ____

____

____

What makes it better: ____

____

What makes it worse: ____

____

What types of treatment have you tried and what was the outcome of treatment: ____

____

____

Please rate your general energy level on a scale of 1 to 10 (1 = exhausted): ____

Do you sleep well: _____ Do you wake feeling rested: _____ If you wake during the night, what time(s) do you wake: __________________________

Does your condition interfere with your normal work, household, or recreational activities? If so, please explain: ______________________________

____

MEDICAL HISTORY:

Major Illnesses: ____

____

Surgeries (include month and year if known): ____

____

Do you have any scars (please list locations): ____

____

Significant Traumas (auto accidents, falls, etc): ____

____

Allergies: ____

____

Medication/Supplements (please list, include reason for taking): _______________________________________

____

____

Exercise (type, duration, number of times per week): ____

____

Hobbies/Interests: ____

Please describe your typical daily diet:

Breakfast: ____________________________________ Lunch: _________________________________

Dinner: ______________________________________ Snacks: _______-_____________________________

Personal Habits (include amount per day):

Coffee/Caffeine: __________Tobacco: __________ Recreational Drugs: _________Alcohol: __________ Refined Sugar: __________

FAMILY MEDICAL HISTORY: (please check if any of the following applies to any family members)

___AIDS ____Alcoholism ____Allergies ____Asthma ____Cancer ____Diabetes ____Heart Disease

___Hypertension ____Seizures ____Stroke ____Pulmonary Disease ____Other (list):_________________________

FEMALES:

Age first menses: _____Age stopped: _____ Number of days between cycles: _____ Number of days of flow: _____ Are your periods regular: _____

Date of last menses: ________ Type of flow (indicate number of days) : _____ light _____ med ____ heavy ____ spotting ____ clots (y/n)

Do you have pain: _____ before ____during ____after Color of flow (indicate number of days): _____red _____dark red _____ purple

Do you have: _____ painful breasts _____ mood swings _____ anger/irritability _____ bloating _____ headaches _____ food cravings

_____ hot flashes _____ night sweats _____ insomnia _____vaginal dryness _____ vaginal discharge _____ endometriosis/fibroids _____ PCOS

Are you currently pregnant (if so, how many weeks) ______ Are you taking birth control ______ Number of pregnancies: _______

Number of births: _____ Miscarriages: _____ Abortions: _____ Number of C-Sections: _____

MALES:

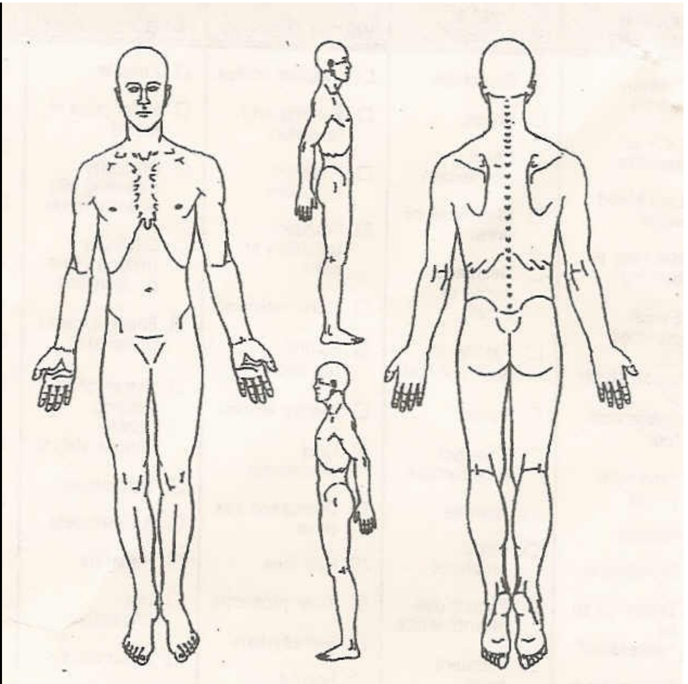
____Erectile Dysfunction ____Premature ejaculation ____ Pain in genitals ____ Prostatitis/BPH ____Decreased Libido ___________________Other

Please check if any of the following applies:

EARTH ELEMENT	METAL ELEMENT	WATER ELEMENT	WOOD ELEMENT	FIRE ELEMENT	MISC
□ Heaviness anywhere in body	□ Dry Cough	□ Swollen Ankles	□ Anemia	□ Heart palpitations	□ Dry Skin
□ Fatigue	□ Cough with sputum	□ Burning with Urination	□Bitter taste in mouth	□ Chest pain	□ High Energy
□ Hard to get up in morning	□ Nasal discharge	□ Frequent Urination	□ Difficulty making plans Or decisions	□ Dizziness	□ Fatigue or Tendency to Faint
□ Edema/Swelling	□ Nosebleeds	□ Frequent Urination at night	□ Easily Angered Or Agitated	□ Easily startled	□ Tendency to be Hot
□ Muscles feel tired often	□ Decreased Sense Of Smell	□ Urine Retention	□ Eye Problems (itching,tearing, Blurred vision)	□ Restlessness/ agitation	□ Tendency to be Cold
□ Easy bruising/ bleeding	□ Itchy, red, or painful throat	□ Painful Urination	□ Gall Stones	□ Anxiety	□ Sudden Weight Loss
□ Bad breath	□ Dry mouth	□ Kidney Stones	□ Hemorrhoids	□ Vivid dreams	□ Sudden Weight Gain
□ Low appetite	□ Skin rashes	□ Cold Intolerance	□ Hepatitis	□ Lack of joy in life	
□ Snacking often	□ Itchy skin	□ Decreased Sex Drive	□ High cholesterol	□ Frequent Crying	
□ Low blood sugar	□ Asthma	□ Hair Loss	□ Impatience	□ Heat Intolerance	
□ Difficulty digesting foods	□ Grief, sadness	□ Knee Problems	□ Depression	□ Laughing for no reason	
□ Nausea	□ Shortness of breath	□ Nightsweats	□ Light clored Stool	□ Irregular Heartrate	
□ Vomiting	□ Allergies	□ Fearful	□ Pain under ribs	□ Insomnia	
□ Gas/belching	□ Low resistance to colds or flu	□ Ringing in Ears	□ Soft/brittle nails	□ Craving or avoiding bitter foods	
□ Bloating	□ Low physical stamina	□ Burning Hands And Feet	□ Spasm or Twitching Muscles		
□ Constipation	□ Mild fever comes and goes	□ Blood in Urine	□ Joints feel stiff/ tight		
□ Diarrhea	□ Swollen Lymph Glands	□ Low Blood Pressure	□ Stiff neck/ Shoulders		
□ Abdominal pain	□ Craving or avoiding spicy foods	□ Craving or avoiding salty foods	□ Varicose Veins		
□ Indigestion/ Heartburn		□ Stress	□ Craving or avoiding sour foods		
□ Over-thinking		□ Sleeplessness	□ High Blood Pressure		
□ Obsessiveness		□ Dizziness	□ Fever Blisters		
□ Craving or avoiding sweets		□ Dark Circles Under Eyes	□ Clenching teeth at night		
		□ Low Back Pain			
		□ Hearing Impairment			

Please indicate areas of the discomfort by using the symbol that best describes the feeling:
+++ = Sharp Stabbing **VVV** = Dull/Aching **OOO =** Pins & Needles /// = Numbness

ACTIVITY	NORMAL	MILDLY LIMITED	MODER-ATELY LIMITED	SEVERELY LIMITED
Lifting	□	□	□	□
Bending	□	□	□	□
Standing	□	□	□	□
Walking	□	□	□	□
Sitting	□	□	□	□
Climbing Stairs	□	□	□	□
Running	□	□	□	□
Resting in Bed	□	□	□	□
Inter-course	□	□	□	□
Computer Work	□	□	□	□



PATIENT CONSENT FOR TREATMENT & ADMINISTRATIVE INFORMATION

Financial Terms: Upon verification of health plan coverage and policy limits, your insurance carrier will be billed for you and your Provider will be paid directly by the carrier. You will be responsible for any applicable deductibles and co-payments. Co-payments must be paid at the time of services are rendered. If you are not eligible at the time services are rendered, you are responsible for payment in full. If your insurance company fails to pay in a timely manner, you may be responsible for payment in full.

Cancelled/Missed Appointments: If you are unable to keep your appointment please allow 24 hrs notice. Missed or cancelled appointments, with less than 24 hr notice, will be billed directly at $65 per missed appointment. Your health plan does not cover missed appointments.

Release of Information: I authorize the release of information regarding my care for payment of claims, certification/health management decisions, and other purposes related to the administration of benefits for my Health Plan.

Consent for Treatment: I hereby request and consent to the performance of acupuncture treatments and other procedures, including various modes of physiotherapy (or the patient named below, for whom I am legally responsible). I understand that methods of treatment may include but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese massage), Asian or western herbal medicine, and nutritional counseling. I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture and other procedures.
Acupuncture has the affects to normalize the physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last for a few days. There have been very rare instances reported of fainting, infection, and scarring. There may be some bruising after cupping/gua sha.
The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Asian medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reaction to the herbs/nutritional supplements, I will inform my acupuncturist.
I do not expect my acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on my acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, are in my best interest. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand and agree to the information outlined above:

____
Patient's Signature Date

____
Guardian/Representative’s Signature Date