Acupuncture Registration Form

Personal Information

Today's date:______________

Name: ______________________________ Date of Birth: _______________ Age: ________SSN: ___________________

Address:____

City: _________________ State: ____ Zip: ________ Home Phone: _________________ Cell Phone: _______________

Employer: ________________________ Occupation: ______________________ Work Phone: _____________________

Emergency Contact Person: _____________________ Relationship: ___________________ Phone # _________________

Address:____

Have you been treated by acupuncture or oriental medicine before? Yes ☐ No ☐

Have you been treated by manipulation before? Yes ☐ No ☐

Insurance Information

Person responsible for account: _______________________ Relationship: _____________ Insured's DOB: _____________

Primary Insurance: ________________________ Group #: __________________ Subscriber #: ______________________

Secondary Insurance: ______________________ Group #: __________________ Subscriber #: ______________________

Health Problems – Please list your main health problems, duration, and current treatments

1. ____
2. ____
3. ____
4. ____

Past Medical History (Please include date)

Cancer ______Diabetes ______Hepatitis ______High Blood Pressure ______Heart Disease ______Rheumatic Fever _____

Thyroid Disease ______Seizures ______Venereal Disease ______Surgeries (type and date) __________________________

____Significant Trauma (auto accidents, falls, etc.) ________

____Significant dental work _____________________________

Allergies

Allergies ____

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HOLISTIQUE Medical Center
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Personal Health History

General:
□ Poor appetite
□ Fevers
□ Sweat easily
□ Localized weakness
□ Bleed or bruise easily
□ Peculiar tastes or smells
□ Strong thirst (hot or cold)
□ Thirst, no desire to drink
□ Sudden energy drop – What time of day? _____
□ Poor sleeping
□ Chills
□Tremors
□ Poor balance
□ Fatigue
□ Night sweats
□ Cravings
□ Change in appetite
□ Weight gain
□ Weight loss

Gastrointestinal:
□ Nausea
□ Constipation
□ Black stools
□ Bad breath
□ Abdominal pain or cramps
□ Chronic laxative use
□ Vomiting
□ Gas
□ Blood in stools
□ Rectal pain
□ Diarrhea
□ Belching
□ Indigestion
□ Hemorrhoids
□ Other _______________

Skin and Hair:
□ Rashes
□ Itching
□ Dandruff
□ Change in hair or skin
□ Ulcerations
□ Eczema
□ Loss of hair
□ Hives
□ Pimples
□ Recent moles
□ Other _____________

Respiratory:
□ Cough
□ Bronchitis
□ Difficulty in breathing when lying down
□ Production of phlegm, what color?□□________
□ Coughing blood
□ Pneumonia
□ Asthma
□ Pain with a deep breath
□ Other lung problems

Pregnancy & Gynecology:
□ Number of pregnancies
□ Number of births
□ Premature births
□ Miscarriages
□ Abortions
□ Age at first menses
□ Period between menses
□ Duration
□ First date of last menses
□ Unusual character (heavy or light)
□ Painful periods
□ Vaginal discharge
□ Clots
□ Vaginal sores
□Irregular periods
□ Las pap smear
□ Breast lumps
□ Do you practice birth control? Yes ĺ No ĺ

Musculoskeletal:
□ Neck pain
□ Back pain
□ Hand/wrist pain
□ Muscle pains
□ Muscle weakness
□ Shoulder pain
□ Knee pain
□ Foot/ankle pain
□ Hip pain

Gento-Urinary:
□ Pain on urination
□ Urgency to urinate
□ Decrease in flow
□ Frequent urination
□ Unable to hold urine
□ Impotency
□ Blood in urine
□ Kidney stones
□ Sores on genitals
□ Other:_________

Head, Eyes, Ears, Nose & Throat:
□ Dizziness
□ Glasses
□ Poor vision
□ Cataracts
□ Ringing in ears
□ Sinus problems
□ Grinding teeth
□ Teeth problems
□ Concussions
□ Eye strain
□ Night Blindness
□ Blurry vision
□ Poor hearing
□ Nose bleeds
□ Facial pain
□ Jaw clicks
□ Migraines
□ Eye pain
□ Color blindness
□ Earaches
□ Spots in front of eyes
□ Recurrent sore throat
□ Sores on lips or tongue
□ Headaches. When and where: ____________

Cardiovascular:
□ Obesity
□ High blood pressure
□ Irregular heart beat
□ Cold hands or feet
□ Blood clots
□ Low blood pressure
□ Dizziness
□ Swelling of hands
□ Phlebitis
□ Chest pain
□ Fainting
□ Swelling of feet
□ Difficulty in breathing
□ Other ____________

Neuropsychological:
□ Seizures
□ Areas of numbness
□ Concussion
□ Bad temper
□ Dizziness
□ Lack of coordination
□ Depression
□ Easily susceptible to stress
□ Loss of balance
□ Poor memory
□Anxiety
□ Other neurological or psychological problems

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Other Problems:
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