PATIENT REGISTRATION – *Please Print Clearly*

LAST NAME	FIRST	MIDDLE	GENDER	DOB	HOME PHONE #

ADDRESS	WORK PHONE #

CITY	STATE	ZIP	MARITAL STATUS □ S □ M □ D □ W	CELL PHONE #

OCCUPATION (IF CHILD, PARENT)	E-MAIL:

EMPLOYER

IF CHILD, PARENT NAME	PARENT ADDRESS if different

SPOUSE NAME & PHONE #	EMERGENCY CONTACT & PHONE #

WHO REFERRED YOU	PRIMARY CARE PHYSICIAN	CONTACT PHONE #

PATIENT RECORD OF DISCLOSURES *(All patients must sign)*

In general, the HIPPA privacy rule gives the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone _____
- □ O.K. to leave a message with detail information
- □ Leave message with call back number only

□ Written Communication
- □ O.K. to mail to my home address
- □ O.K. to fax to this number:

□ Work Telephone _____
- □ O.K. to leave a message with detail information
- □ Leave message with call back number only

□ Written Communication
- □ O.K. to mail to my work/office address

_____ _____

Patient signature / Print name Date

PATIENTS AUTHORIZATION (*All patients must sign*)

Payment is due at the time service is rendered, unless alternative arrangements are made prior to treatment. The issue of insurance payment is between you and your insurance carrier. We accept cash, check, Visa & MasterCard, or money order. I agree to promptly pay all charges for services rendered and accept legal responsibility for any and all charges for patient named above. I authorize acupuncture treatment by Yanqiu He, OMD, L.AC. I understand that the practitioner is not primary care provider. I authorize the release of any necessary information including medical records to my insurance carrier. I permit a copy of this authorization to be used in the place of the original. Either the above-named carrier or I may revoke this authorization at any time in writing. I certify that I represent only myself of individual (s) for whom I am a guardian and am not here on behalf of a third party.

Date _____ Signature of Patient / Responsible Party _____

Date: _____

Medical History Questionnaire

NAME **AGE** **HEIGHT** **WEIGHT** **BLOOD TYPE**

PRESENTING HEALTH PROBLEM(S) & DESCRIPTION

TREATMENTS & RESULTS

HISTORY OF PRESENT ILLNESS: Describe how and when the problems began and progressed

CURRENT MEDICATIONS DOSE & FREQUENCY

RESPONSE TO MEDICATIONS

CURRENT SUPPLEMENTS DOSE & FREQUENCY

RESPONSE TO MEDICATIONS

DRUG ALLERGIES: *List and describe reactions to drugs, medications, or anesthetics.*

Allergies to Foods?
□ Milk products
□ Wheat or other grains
□ Food dyes, additive
□ Others

Allergies to Inhalants?
□ Dust
□ Grass. trees. pollen
□ Animal dander
□ Mold

Reactions to Chemicals?
□ Chlorine, formaldehyde
□ Cosmetics, detergents, perfumes
□ Gas, glues, newsprint. paint, dye
□ Smoke

INJURIES (SPRAINS, FRACTURES, SURGERIES DISLOCATIONS & SCARS) DATE

HOSPITALIZATIONS DATE

TESTS	DATE / RESULTS	TESTS	DATE / RESULTS
□ EEG		□ CT Scan	
□ EKG		□ MRI	
□ EMG		□ Stress Test	
□ SCAN		□ X-rays	

FAMILY HISTORY: check any which has effected your parents, grandparents, siblings, children.

Condition	Relative/s Affected	Condition	Relatives Affected	Condition	Relatives Affected
□ Addiction(s)		□ Depression		□ High Blood P.	
□ Allergies		□ Diabetes		□ Lung Problem	
□ Arthritis		□ Digestive/Intest		□ Overweight	
□ Asthma		□ Genetic Disease		□ Stroke	
□ Bladder		□ Gout		□ Thyroid	
□ Kidney		□ Headache		□ Suicide	
□ Bleeding		□ Migraine		□ Other	
□ Cancer		□ Heart Disease		□ Other	

YOUR HISTORY: Check any of the following that you have now or ever have had.

□ Alcoholism
□ Arthritis
□ Anxiety/Depression
□ Autoimmune Disease
□ Bladder/Kidney
□ Cancer
□ Digestive Problems
□ Diabetes
□ Ear Infections/Prob
□ Eczema/Skin Prob
□ Emphysema I Asthma
□ Epilepsy/Seizures
□ Eye Problem
□ Genetic Condition
□ Headaches
□ Heart Disease
□ High Blood Pressure
□ HIV/AIDS
□ Hormonal
□ Intestinal Problems
□ Muscle Problems
□ Neurological Prob
□ Psychological Prob
□ Respiratory Problems
□ Rheumatic Fever
□ Scarlet Fever
□ Sexually Trans Dis
□ Sinus / Upper Respir
□ Stroke
□ Swallowing Problem
□ Thyroid: Hypo: □ Hyper □
□ TMJ / Jaw Dysfunction
□ Viral: Herpes: □ CMV: □
Polio: □ Mono: □
□ Weight Loss
How much? __ Time? ___
□ Weight Gain:
How much? __ Time? ___
□ Other
_____
_____

Exams

Last Complete Physical ? _____ Results: _____ By whom? _____

Hemoccult (blood in stool)? _____ Results: _____ By whom? _____

Last Sigmoidoscopy of colon? _____ Results: _____ By whom? _____

Females

Last menses? _____ Menopause? □ Yes □ No # of pregnancies __ # of children___
Pregnant? □ Yes □ No
Last Mammogram? _____ Results? _____ Last Pap Smear: _____ Results? _____
Last Breast Exam? _____ Results? _____ Breast Self Examination?
Frequent urination: □ Yes □ No Incontinence: □ Yes □ No
Libido: □ normal □ decreased □ increased Additional: _____

Males

Prostatitis: □ Yes □ No Last Prostate Exam: _____ Result:: _____
Frequent urination: □ Yes □ No Incontinence: □ Yes □ No
Libido: □ normal □ decreased □ increased Additional: _____

Children

Learning problems: □ Yes □ No Poor attention span: □ Yes □ No
Hyperactivity: □ Yes □ No Behavior problems: □ Yes □ No

ACTIVITY LEVEL:
□ Sedentary (inactive) by choice
□ Sedentary (inactive) due to inability or restriction
□ light: light daily work and no regular exercise
□ Moderate: light daily work and exercise 3 X week
□ Sustained: moderate daily work and exercise 5 X week
□ Heavy: heavy work and heavy exercise 5 X week

STRESSORS AFFECTING YOUR LIFE:
□ Difficulties with work or lifestyle
□ Recent change in marital status
□ Death or serious illness family or friend
□ Dysfunctional family □ Past □ Present
□ Lack of love or fulfilling relationships
□ Illness - self!

Review of Systems

For "Past": V if it applies nor "Now" - Rate 0 - 3: 0 = Not present 1 = Mild 2 = Moderate 3 = Severe

Symptoms	Past	Now	Comments
General / Immune			
Frequent Fatigue			
Hot / Heat Intolerant			
Cold/ Cold Intolerant			
Perspire Easily			
Lack of Perspiration			
Frequent Infections			
Immune / Auto-immunity			
History of "Mono"			
Swollen Glands			
Endocrine			
Low body temperatures			
Cold Extremities			
Thyroid Disorder			
Dizzy Upon Standing			
Low Blood Pressure			
Skin/ Nails			
Acne, Eczema, Dermatitis			
Brown Spots			
Gooseflesh / Folliculitis			
Hives / Rashes			
Itch Burning, Dry			
Oily			
Pale			
White Spots: Loss of Pigment			
Yellow Tone			
Nails: Brittle, Peeling			
Ridges			
White Lines			
Head and Neck			
Headaches			
Migraines			
Head injury			
Face / Jaw Pain			
Neck Pain, Stiff Neck			
Hair. Brittle Dry			
Hair Loss of Color			
Hair Loss			
Eyes			
Wear Glasses			
Blurred Vision			
Blood Shot			
Burning / Dry / Itching			
Cataracts			
Floaters (see Spots)			
Glaucoma / Retina Problems			
Light Sensitive			
Night Blind			
Cardiovascular			
High Blood Pressure			
Chest Pain			
Dizzy Spells			

Symptoms	Past	Now	Comments
Ears			
Ear Infections			
Itching			
Hard Ear Wax			
Ringing /Tinnitus			
Nasal			
Bleeds			
Burning / Dryness / Crusts			
PND/ Rhinitis			
Sinusitis			
Sense of Smell Loss			
Mouth/Throat			
Bleeding Gums			
Bone Loss (Periodontitis)			
Bruxism (Grinding)			
Face / Jaw Pain / TMJ			
Fillings: Silver / Mercury			
Lip Cracks			
Mouth Ulcers			
Swallowing Problem			
Taste Loss			
Tongue coated			
Tongue Fissured			
Voice Hoarse			
Digestive			
Belching, Bloating, Gas			
Colitis / Irritable Bowel			
Constipation			
Diarrhea			
Gastritis, Pain, Ulcer			
Heartburn, Reflex			
Hemorrhoids/Rectal Bleed			
Liver/Gall Bladder			
Nausea / Vomiting			
Stool: Dark green / black			
Blood			
Mucous			
Yellow			
Respiratory			
Asthma			
Bronchitis			
Cancer - Lung			
Chemically Induced Prob			
Chest pain			
Colds + Flu (frequency)			
Cough - chronic			
Exercise Induce Problems			
Shortness of Breath			
Male			
Discharge			
Impotence			
Lumps			

Symptoms	Past	Now	Comments
Leg Pain With Walking			
Numb Extremities			
Palpitations / Tachycardia			
Stroke			
Varicosities			
Muscles & Joints			
Arthritis/Joint Pain			
Back Pain / Disc Problems			
Bursitis/Tendonitis			
Muscle Aches / Pains			
Muscle Cramps / Spasms			
Muscle Weakness			
Neurological			
Clumsy			
Convulsions / Seizures			
Fainting Spells			
Neuralgia I Tingling			
Numbness			
Raynaud's			
Spastic Motion / Tremors			
Urinary			
Bladder Infectious - frequent			
Blood in Urine			
Frequent Urination			
Incontinence			
Kidney Stones			
Pain, Burning			
Behavioral & & Psychological			
Addictions (list)			
Anxiety			
Attention Deficit (ADD)			
Bizarre Behavior			
Depression			
Developmental Delays			
Eating Disorder (list)			
Fearful / Worrier			
Hyperactive / Manic			
Insomnia			
Lack of Dream Recall			
Learning Problems			
Memory Problems			
Mood Swing			
Narcolepsy - Oversleeping			
Obsessive / Compulsive			
Phobias			
Schizophrenia			
Suicidal			

Symptoms	Past	Now	Comments
Pain- Testicular			
Prostate Problems			
Weak Urine Stream			
STD's			
Female			
Breasts: Cancer			
Fibrocystic			
Sore			
Endometriosis			
Fibroids / Cysts			
Hormone Replacement			
Hot Flashes			
Periods: Cramps			
Heavy Flow			
Irregular			
Infertility			
Peri-menopausal			
Menopausal: Natural			
Surgical			
Night Sweats			
Osteoporosis			
Ovarian/Uterine Cancer			
Painful Intercourse			
Pap Smears - abnormal			
Pre-Menstrual Tension			
Pregnancies: Incomplete			
Full Term			
Sexually Transmitted Dis.			
Vaginal: Dryness			
Infection			
Inflammation			
Yeast			
Discharge			
Spotting			
Foods / Glucose Tolerance			
Afternoon Drowsiness			
Cravings : Butter/Fats			
Foods (list)			
Ice			
Fatigue After Eating			
Hunger Headaches			
Hunger Irritability			
Skin Crawling Sensations			
Symptoms from Foods			
Other			
Best time of the day			
Worst time of the day			
Best season for you			
Worst season for you			