AcuHealth, LLC

NEW PATIENT REGISTRATION FORM

This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you.
If you have questions/concerns regarding any of the following, please ask. Thank you.

Full Name _____ Name preference _____ Date _____

Home Address _____

City _____ State _____ Zip _____ Email Address _____

Home Phone (___) _____ Work (___) _____ Cell (___) _____

Best # to call (___) _____ OK to leave message? ☐ Y ☐ N Best time to call ____AM ____PM

Emergency contact: _____ Relationship: _____ Phone: (___) _____

AcuHealth, LLC will never sell or transfer your information to third parties.
May we send you updates & information? ☐ Y ☐ N
May we contact you by email? ☐ Y ☐ N by regular post? ☐ Y ☐ N

Age _____ Date of birth _____ Gender: ☐ F ☐ M Height _____ Weight _____

Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed #Number of children _____

Occupation _____ Employer _____

Whom may we thank for referring you? _____

What is the reason for today's visit? _____

_____

If "pain" is this due to: ☐ Auto accident ☐ Injury/Trauma ☐ Work-related ☐ Other: _____

_____ Date of accident/injury/onset _____

How long have you had this? _____ Have you had this before? ☐ Y ☐ N

If yes, when? For how long? _____

Have you sought other treatment/consulted another medical professional for this? ☐ Y ☐ N
If yes, what and when? _____ Was this helpful? ☐ Y ☐ N

_____

Doctor's Name _____ Phone _____

Address _____

Date of last physical _____

Please list any other health problems/concerns you have: _____

_____

What are your health goals? _____

Short term goals (1-4 weeks) _____

Long term goals (1-12 months)

FAMILY MEDICAL HISTORY: Are you adopted? ☐ Y ☐ N

Please check "☐" all that apply & indicate you and/or a blood relative (grandparent, parent, sibling).

	You	Relative-who?	Date		You	Relative-who?	Date
Alzheimer's	___	_____	_____	Arthritis	___	_____	_____
Cancer	___	_____	_____	Diabetes	___	_____	_____
Emotional disorders	___	_____	_____	Gallbladder disease	___	_____	_____
Heart disease	___	_____	_____	Hepatitis	___	_____	_____
High blood pressure	___	_____	_____	Infectious disease	___	_____	_____
Neurological disorder	___	_____	_____	Rheumatic Fever	___	_____	_____
Seizures	___	_____	_____	Stroke	___	_____	_____
Thyroid disorder	___	_____	_____	Tuberculosis	___	_____	_____
Other: _____	___	_____	_____	Other: _____	___	_____	_____

DIAGNOSTIC TESTING: Please check "☐" all that apply.

___ Blood work When? _____ Results: _____
___ CT scan When? _____ Results: _____
___ EKG When? _____ Results: _____
___ MRI When? _____ Results: _____
___ Urinalysis When? _____ Results: _____
___ X-Ray When? _____ Results: _____
___ Other: _____ When? _____ Results: _____

HOSPITALIZATIONS:

If you have been hospitalized for any serious medical illness, injury, or surgery, please write in your most recent hospitalization(s) below. Check "☐" this box ☐ if you had more than three such hospitalizations. (Do not include normal pregnancies).

Most recent hospitalization: _____

	Year	Operation/Illness	Hospital/City/State
Previous hospitalization:			
Previous hospitalization:			

MEDICATIONS/SUPPLEMENTS: Please check "☐" the box ☐ next to all you are currently taking.

☐ Advil/Ibuprofen/Tylenol	☐ Cold medication	☐ Hormone Replacement
☐ Allergy medication	☐ Oral contraceptive medication	☐ Interferon
☐ Antacids	☐ Coumadin/Warfarin	☐ Laxatives
☐ Antibiotics	☐ DHEA/Melatonin	☐ Steroids
☐ Antidepressants	☐ Diet pills	☐ Supplements: vitamin/mineral
☐ Aspirin	☐ Diuretics	☐ Tranquilizers/sleeping pills
☐ Blood pressure medication	☐ Herbal formulas/tinctures	☐ Viagra

Please list the names of all medications/supplements you are currently taking (continue on back, if needed):

Medicine/Dosage **Reason** **How Long** **Prescribed by** **Last checkup**

_____
_____
_____
_____

LIFESTYLE HABITS: Please check "☐" the box ☐ next to all that apply.

Alcohol	☐ ☐No	☐ ☐Yes	If yes, # drinks/week _____ Age started ____
Artificial sweetener	☐ No	☐ Yes	If yes, how much? _____
Caffeine	☐ ☐No	☐ ☐Yes	# coffees/day _____ # sodas/day _____ # teas/day _____
Exercise	☐ No	☐ Yes	If yes, ☐ ☐Daily ☐ ☐Weekly ☐ Monthly ☐ Rarely ☐ Never
Recreational Drugs	☐ ☐No	☐ ☐Yes	If yes, ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
Tobacco	☐ No	☐ Yes	If yes, # cigarettes/cigars/day _____ Age started ____
Water Intake	☐ ☐No	☐ Yes	If yes, how much? _____

SYMPTOM SURVEY: Following is a list of symptoms you may or may not ever experience.
Please check "□" as follows: Never experience: ___ (leave blank)
Sometimes experience: "□"
Frequently experience: "□ □"

___ cough
___ nasal problems
___ bronchitis
___ hemorrhoids
___ coughing blood
___ shortness of breath
___ feelings of claustrophobia
___ colitis or diverticulitis
___ recent antibiotic use
___ production of phlegm:
Color: _____
___ decreased sense of smell
___ sinus congestion
___ constipation
___ skin problems
Please detail: _____
_____

___ insomnia/difficulty sleeping
___ nightmares
___ angina pain
___ mentally restless
___ laughing for no apparent reason
___ heart palpitations
___ abdominal pain
___ pain or coldness in genitals
___ cold hands and feet
___ chest pain
___ sciatic pain
___ headache/where?_____

___ lack of appetite
___ digestive problems
___ tendency to obsess: work, relationships, etc
___ excessive appetite
___ vomiting
___ feeling of retention of food in the stomach
___ loose stools or diarrhea
___ belching, burping
___ heartburn/reflux
___ bloating, gas

___ jaundice
___ light colored stools
___ difficulty making decisions
___ eye problems/floaters
___ difficulty digesting oily foods
___ soft or brittle nails
___ easily angered/agitated
___ muscle spasms/twitching
___ gallstones
___ eye twitching
___ tendency to faint
___ fibrocystic breasts

___ low back pain
___ ear ringing
___ hair loss
___ edema
___ easily bruised
___ allergies
___ tendency to catch colds
___ nighttime urination #_____
___ knee problems
___ kidney stones
___ urinary problems
___ blood in stool
___ difficulty stopping bleeding
___ hay fever
___ intolerance to changes in weather/season
___ impaired hearing
___ decreased sex drive
___ urinary infection
___ black tarry stools
___ asthma
___ dizziness
___ head injury
date: _____

Sexually transmitted infections: ___Gonorrhea ___Syphilis ___HIV ___Chlamydia ___Herpes
Related medications: _____

CRAVINGS: ___ Salty ___ Sour ___ Sweet ___ Fatty/Greasy ___ Snacks btwn meals

DIET: ___ Macrobiotic ___ Raw food ___Vegan ___ Vegetarian ___ Other: _____

SKIN: ___ Acne ___ Dandruff ___ Eczema ___ Itching ___ Psoriasis ___ Rashes

SWEAT: ___ Easily ___ Rarely ___ Hot flashes ___ Night sweats ___ Palms/Feet ___ All-over

TEMPERATURE: ___ Feel cold: Where? _____ ___ Feel hot: Where? _____ ___ Fever/chills

MENTAL / EMOTIONAL SELF-REPORT: Please circle the number that describes you.

How do you feel about:	**Fair → Great**		**Fair → Great**
Your Life	**1 2 3 4 5**	Your Creativity	**1 2 3 4 5**
Your Health	**1 2 3 4 5**	Your Physical Activity	**1 2 3 4 5**
Your Family	**1 2 3 4 5**	Your Spirituality	**1 2 3 4 5**
Your Relationships	**1 2 3 4 5**	Your Profession	**1 2 3 4 5**

WOMEN:

Age at first menstrual period: ___ Age at menopause: ___ Number of days between periods: _____

Number of days of flow: _____ Color of flow: _____ Clots? ☐ Y ☐ N Color: _____

Number of pads/tampons you use per day: Day 1 ____ Day 2 ____ Day 3 ____ Day 4 ____ Day 5 ____

Have you been diagnosed with: ☐ Cysts ☐ Fibrocystic breasts ☐ Fibroids ☐ Endometriosis ☐ PCOS

Other symptoms related to menstruation: _____

Please check box next to all that apply. Circle before **"B,"** during **"D,"** or after **"A"** menses:

PAIN:	☐ Aching	B D A	☐ Burning	B D A	☐ Cramping	B D A
	☐ Dull	B D A	☐ Sharp	B D A	☐ Stabbing	B D A
	☐ Intermittent	B D A	☐ Constant	B D A	☐ "Bearing down" sensation	B D A
☐ Vaginal dryness	B D A	☐ Discharge ___/Color _____ ___/Odor_____				
☐ Constipation	B D A	☐ Diarrhea	B D A	☐ Headache	B D A
☐ Swollen breasts	B D A	☐ Bloating	B D A	☐ Nausea	B D A
☐ Night sweats	B D A	☐ Insomnia	B D A	☐ Hot Flashes	B D A
☐ Mood swings	B D A	☐ Low appetite	B D A	☐ Big appetite	B D A
☐ Increased libido	B D A	☐ Low libido	B D A	☐ Cravings	B D A

Pregnancy History: Are you pregnant? ☐ Y ☐ N If "yes," what is your due date? _____
pregnancies _____ # live births _____
abortions _____ # miscarriages _____

Do you want to become pregnant? ☐ Y ☐ N Are you currently trying to get pregnant? ☐ Y ☐ N

Date/results of most recent:
Gynecological exam: _____ PAP smear: _____

Bone density scan: _____ Mammogram: _____

MEN:

Date of most recent prostate check-up: _____ PSA results: _____

Manual prostate exam and lab results: _____

Frequency of Urination: Daytime: # _____ Nighttime: # _____

Color of Urine: ☐ Clear ☐ Cloudy ☐ Yellow ☐ Dark ☐ Strong odor

Please check box next to all that apply:

☐ Back pain	☐ Testicular pain	☐ Groin Pain	☐ Painful urination
☐ Dribbling	☐ Incontinence	☐ Delayed stream	☐ Retention of Urine
☐ Impotence	☐ Decreased libido	☐ Increased libido	☐ Premature ejaculation
☐ BPH/prostate	☐ Weak erections (ED)	☐ Rectal dysfunction	☐ Decreased force of stream

Are you and your spouse/partner currently trying to get pregnant? ☐ Y ☐ N

If you have been unable to conceive, have you had medical testing for this issue? ☐ Y ☐N
If yes, what were the results: _____

PAIN:

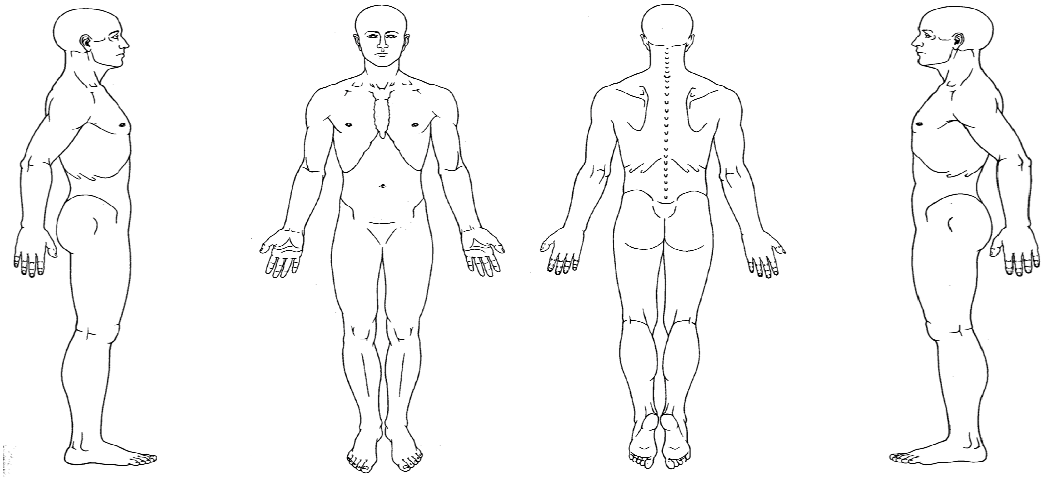
Are you currently experiencing acute or chronic pain? ☐ Y ☐ N If so, please describe:_____

_____

What activities cause this pain or make it worse: _____

What makes it better: _____

Please shade in your pain pattern below – use heavier shading in areas of more intense pain: **Patient's Right side**
Patient's Left side



ALL PATIENTS: Please check box for any of the following that are true:

☐ I have known allergies. If so, please list any allergies (medications, etc) or food sensitivities you have:

_____

☐ I'm taking a blood thinner (Coumadin/Warfarin). ☐ I have a Pacemaker. ☐ I'm taking Lithium.

Have you received acupuncture before? ☐ Y ☐ N If so, when? _____

With whom? _____

Are there any issues of emotional/physical/sexual trauma or abuse you would like to discuss? ☐ Y ☐ N

Are there any other issues or concerns you'd like to discuss? ☐ Y ☐ N

The above information is accurate and true to the best of my knowledge. I understand that an acupuncture appointment could include acupuncture, cupping, guasha, moxabustion, dietary or nutritional counseling, flower essences, herbal formulas, homeopathic remedies, Qigong or other breathing exercises, stretching, therapeutic massage, and bodywork. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I understand that I am responsible for full payment for any and all scheduled appointments, including missed appointments and appointments cancelled without 24 hours notice (excepting emergency situations). Payment is due at time of service. **AcuHealth, LLC** abides by HIPAA guidelines and respects the privacy of all patients. I have been provided a copy of the **AcuHealth, LLC ~ Notice of Privacy Practices**. If I have questions or concerns before, during, or after treatment, I will bring them to the attention of my practitioner.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____