acupuncture registration | health history

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID No. _____

Patient Name _____
First

_____
Middle *Last*

Address _____

_____

City _____ State _____ Zip _____

E-mail _____

Sex: ❍ M ❍ F Age _____

Birth Date _____ SS No. _____

❍ Married ❍ Widowed ❍ Single ❍ Minor

❍ Separated ❍ Divorced ❍ Partnered for ____ years

Patient Employer / School _____

Occupation _____

Employer / School Address _____

Employer / School Phone (____) _____

Spouse's Name _____

Birth Date _____ SS No. _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

INSURANCE INFORMATION

Primary Insurance Co. _____

Group No. _____ ID No. _____

Subscriber's Name _____

Birth Date _____ SS No. _____

Relationship to Patient _____

Is patient covered by secondary insurance? ❍ Yes ❍ No

Secondary Insurance Co. _____

Group No. _____ ID No. _____

Subscriber's Name _____

Birth Date _____ SS No. _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I, and / or my dependents(s), have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. Rich all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of patient, parent, guardian or personal representative

_____
Please print name of patient, parent, guardian or personal representative

_____ _____
Date *Relationship to Patient*

PHONE NUMBERS

Cell Phone _____ Home Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

ACCIDENT INFORMATION

Is condition due to an accident? ❍ Yes ❍ No Date _____

Type of accident ❍ Auto ❍ Work ❍ Home ❍ Other

To whom have you made a report of your accident?

❍ Auto Insurance ❍ Employer ❍ Workers Comp ❍ Other

Attorney name (if applicable) _____

MEDICATIONS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

VITAMINS / HERBS / MINERALS

_____

_____

Pharmacy Name _____

Pharmacy Phone (_____) _____

[CORE]
CHIROPRACTIC AND WELLNESS

SYMPTOM SURVEY

Please "check" the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
❍ excessive appetite	❍ insomnia	❍ cough	❍ low back pain	❍ eye problems
❍ loose stool/diarrhea	❍ palpitations	❍ shortness of breath	❍ knee problems	❍ jaundice
❍ digestive problems,	❍ cold hands and feet	❍ decreased sense of smell	❍ hearing impairment	❍ difficulty digesting oily foods
❍ vomiting	❍ nightmares	❍ nasal problems	❍ ear ringing	❍ gall stones
❍ belching, burping	❍ mentally restless	❍ skin problems	❍ kidney stones	❍ light-colored stool
❍ heartburn/reflux	❍ laughing for no reason	❍ claustrophobia	❍ decreased sex drive	❍ soft or brittle nails
❍ stomach bloating	❍ chest pains	❍ colitis/diverticulitis	❍ hair loss	❍ easily angered
❍ obsession in work	❍ poor memory	❍ constipation	❍ urinary problems	❍ difficult relationships
❍ blood in stool	❍ sadness	❍ allergies	❍ dental problems	❍ difficulty making decisions
❍ lack of appetite	❍ depression	❍ asthma	❍ fatigue	❍ dizziness
❍ hemorrhoids	❍ Anxiety	❍ get sick easily	❍ edema	❍ headaches
❍ easily bruised				
❍ I usually feel warm	❍ I usually feel chilled			

KIDNEY YIN XU

- ❍ Do you have lower back weakness, soreness or pain?
- ❍ Do you have ringing in your ears?
- ❍ Is your hair prematurely gray?
- ❍ Do you have dark circles under your eyes?
- ❍ Do you have night sweats?
- ❍ Are you prone to hot flashes?
- ❍ Would you describe yourself as "afraid" frequently?
- ❍ Do you have dizziness?
- ❍ Do you have knee problems?

For Women only:

- ❍ Do you have vaginal dryness?
- ❍ Is your mid-cycle cervical mucus scanty or missing?

KID YANG XU

- ❍ Is your back sore or weak?
- ❍ Are your feet cold, especially at night?
- ❍ Are you typically colder than those around you?
- ❍ Is your libido low?
- ❍ Are you often fearful?
- ❍ Do you wake up at night or early in the morning because you have to urinate?
- ❍ Do you urinate frequently, and is the urine diluted and/or profuse?
- ❍ Do you have early morning loose, urgent stools?

For Women only:

- ❍ Do you have low back pain pre-menstrually?
- ❍ Do you have profuse vaginal discharge?
- ❍ Do you feel cold cramps during your period that respond to a heating pad?

SPLEEN QI-XUE-YANG XU

- ❍ Are you often fatigued?
- ❍ Do you have poor appetite?
- ❍ Is your energy low after a meal?
- ❍ Do you feel bloated after eating?
- ❍ Do you crave sweets?
- ❍ Do you have loose stools, abdominal pain, or digestive problems?
- ❍ Are your hands and feet cold?
- ❍ Are you prone to feeling sluggish?
- ❍ Are you prone to heaviness or grogginess in the head?
- ❍ Do you have varicose veins?
- ❍ Are you prone to worry?
- ❍ Have you been diagnosed with low blood pressure?
- ❍ Do you sweat a lot without exerting yourself?
- ❍ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- ❍ Are you often sick, or do you have allergies?
- ❍ Have you ever been diagnosed with hypothyroid or anemia?
- ❍ Do you have hemorrhoids or polyps?

For Women only:

- ❍ Is your menstruation thin, watery, profuse, or pinkish in color?
- ❍ Are you more tired around ovulation or menstruation?
- ❍ Do you ever spot a few days before your period comes?
- ❍ Have you ever been diagnosed with uterine prolapse?
- ❍ Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

BLOOD DEFICIENCY

- ❍ Do you have dry, flaky skin?
- ❍ Are you prone to getting chapped lips?
- ❍ Are your fingernails or toenails brittle?
- ❍ Is your hair brittle or dry?
- ❍ Do you have diminished nighttime vision?
- ❍ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

For Women only:

- ❍ Do you get dizzy or light-headed around your period?
- ❍ Are you losing hair on your head?
- ❍ Are your menses scant or late?

BLOOD STASIS

- ❍ Do you experience periodic numbness of your hands and feet, especially at night?
- ❍ Do you have varicose or spider veins?
- ❍ Do you have red cherry spots (hemangiomas) on your skin?
- ❍ Do you have chronic hemorrhoids?
- ❍ Do you have dark spots in your eyes?
- ❍ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

For Women only:

- ❍ Does your menstrual blood contain clots?
- ❍ Have you been diagnosed with endometriosis or uterine fibroids?
- ❍ Do you have piercing or stabbing menstrual cramps?
- ❍ your menstrual flow ever brown or black in color?
- ❍ Do you feel mid-cycle pain around your ovaries?
- ❍ Do you have painful, unmovable breast lumps?

LIVER QI STAGNATION

- ❍ Are you prone to emotional depression?
- ❍ Are you prone to anger and/or rage?
- ❍ Are your pupils usually dilated and large?
- ❍ Do you have difficulty falling asleep at night?
- ❍ Do you experience heartburn or wake up with a bitter taste in your mouth?

For Women only:

- ❍ Do you become irritable pre-menstrually?
- ❍ Do you feel bloated or irritable around ovulation?
- ❍ Does it feel as if ovulation lasts longer than it should?
- ❍ Are your breasts sensitive/sore at ovulation?
- ❍ Do you experience pain or discharge from your nipples?
- ❍ Do you have a lot of pre-menstrual breast distension or pain?
- ❍ Do you become bloated pre-menstrually?
- ❍ Are your menses painful?
- ❍ Do you feel your menstrual cramps in the external genital area?
- ❍ Is your menstrual blood thick and dark, or purplish in color?

HEART [ANY DISORDER]

- ❍ Do you wake up early in the morning and have trouble getting back to sleep?
- ❍ Do you have heart palpitations, especially when anxious?
- ❍ Do you have nightmares?
- ❍ Do you seem low in spirit or lacking vitality?
- ❍ Are you prone to agitation or extreme restlessness?
- ❍ Do you fidget?
- ❍ Do you sweat excessively, especially on your chest?

EXCESS HEAT

- ❍ Are your mouth and throat usually dry?
- ❍ Are you often thirsty for cold drinks?
- ❍ Do you often feel warmer than those around you?
- ❍ Do you wake up sweating or have hot flashes?

For Women only:

- ❍ Do you breakout with red acne, especially pre-menstrually?
- ❍ Do you have a short menstrual cycle?
- ❍ Do you have vaginal irritation?

DAMPNESS

- ❍ Do you feel tired and sluggish after a meal?
- ❍ Do you have cystic or pustular acne?
- ❍ Do you have urgent, bright, or foul-smelling stools?
- ❍ Are you overweight?
- ❍ Do you have a wet, slimy tongue?
- ❍ Does your body feel like a barometer? Can you sense when it will rain?

For Women only:

- ❍ Does your menstrual blood contain stringy tissue or mucus?
- ❍ Are you prone to yeast infections and vaginal itching?
- ❍ Do you have fibrocytic breasts?

FOR WOMEN

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow_____

Check All that Apply:

Color of flow: ❍ pale/light red ❍ red ❍ bright red ❍ dark red ❍ dark red/brown ❍ dark red/purple

Number of pads you use per day: ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day

Pain and Cramping: ❍ No ❍ Yes ❍ mild ❍ moderate ❍ severe

❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

Amount of flow:

❍ even throughout

❍ clots ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

❍ spotting ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

❍ light ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

❍ heavy ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

Other symptoms related to menses: ❍ Discharge ❍ PMS ❍ Headache ❍ Swollen Breasts

❍ Constipation ❍ Diarrhea ❍ Nausea ❍ Increased Appetite

❍ Insomnia ❍ Mood Swings ❍ Decreased Appetite

Have you ever been diagnosed with: ❍ endometriosis ❍ ovarian cysts ❍ PID ❍ fibrocystic breasts

❍ fibroids ❍ polycystic ovary syndrome ❍ STD: _____

Fertility Information: Number of IVF procedures _____ Number of IUI procedures _____

Has a physician diagnosed a difficulty with fertility due to:

❍ Female Factor ❍ Male Factor ❍ Unexplained

❍ Other _____