

Healing Ocean Community Acupuncture Registration and Health History

Patient Information	Contact Information
Date _____	Home phone _____
Name _____	Work phone _____
Address _____	Other/cell phone _____
City, State Zip _____	Email _____
Age _____ Birthdate _____	Another person to contact if needed:
Occupation _____	Name _____
Physician _____	Relationship _____
Physician phone number _____	Home phone _____
How did you hear about us? _____	Work phone _____
Current Condition	
What are your primary reasons for treatment?	If in pain, describe its location.
1- _____	_____
2- _____	_____
3- _____	Describe the nature of the pain (ie dull, throbbing, sharp,)
How is your sleep? _____	_____
_____	Is it constant? _____
How is your digestion? _____	When is it worst? _____
_____	_____
Do you easily feel hot or cold? _____	Does it keep you from any activities?
How is your energy? _____	_____
List any medications or food supplements you are taking:	On a scale of 1-10 where 10 is unbearable pain and 1 is no pain.
_____	How are you now? _____
_____	How is it at worst? _____
_____	How is it generally? _____

Health History

Check any symptoms below that you currently have or have had in the past year

Cough	Poor appetite	Bruise easily	Red/itchy eyes
Dry mouth	Loose stools	Nosebleeds	Blurry vision
Phlegm in throat	Belching	Rashes/hives	Sensitive to light
Nasal congestion	Nausea	Blood in stool	Muscle cramps
Chills	Vomiting	Blood in urine	Twitching muscles
Fever	Constipation	Painful urination	Numbness/tingling
Muscle aches	Ravenous hunger	Burning urination	Spasms
Joint pains	Acid reflux	Frequent urination	Migraines/headaches
Hayfever	Bloating	Night sweats	Irritable/easily angered
Asthma	Abdominal pain	Unusual day sweat	Anxiety/nervousness
Short of breath	Fatigue	Heart palpitations	Depression/blues/weepy
Bronchitis	Hemorrhoids	Memory problems	Excessive worry
Wheezing	Mucus in stools	Chest pains	Excessive fear
Skin problems	Dizziness	Difficulty concentrating	Low libido
Allergies	ringing in ears	Lower back pain	Knee problems

For Men Only:

Erection difficulties	Penis discharge	Prostate trouble
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For Women Only:

Bleeding between periods	Clots in menses	Excessive menstrual flow
Extreme menstrual pain	Irregular cycle	PMS
Menopausal symptoms	Previous miscarriage	Scanty menstrual flow

Could you be pregnant? _____

Have you ever had:

Tuberculosis	Mononucleosis	AIDS/HIV	Hepatitis
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Check illnesses that have occurred in blood relatives:

Diabetes	High blood pressure	Cancer	Heart disease
Thyroid problems	Arthritis	Kidney disease	Mental illness

Signature

The information on this form is correct to the best of my knowledge.

Signature _____

Date _____