Innovative
Healing Center
Acupuncture • Massage • Nutrition

Patient Registration

Patient Name: _____ Age: _____

Address: _____
(Street Address) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Employer: _____ Wk Phone: _____

Date of Birth: _____ Email Address: _____

(Please Circle) Male Female Married Single Student: Yes No

Person to Contact in case of Emergency: _____

Phone Number (of person above): _____

Reason(s) for Visit Today: _____

Is this an emergency? Yes No Injury/Illness Date: _____ Similar symptoms before? Yes No

Is your accident related to employment (on-the-job)? Yes No Motor vehicle accident? Yes No

Have you had acupuncture before? Yes No Have you used Chinese Herbal Medicine? Yes No

How long have you had this condition? _____ Is it getting worse? Yes No

Does the condition bother your: sleep work Other? (What) _____

What seems to be the initial cause? _____

What seems to make the condition better? _____

What seems to make the condition worse? _____

Are you under the care of a physician now? Yes No If yes, what for? _____

Who is your physician? _____ Physician Phone #: _____

Concurrent Therapies: _____

Patient Signature: _____Date: _____

Check all that apply:

Your Diet

Appetite □ High
□ Low

□ Coffee
□ Soft Drinks
□ Artificial Sweetener

□ Sugar
□ Salty Food

Thirst for Water:
# of Glasses per Day: _____

Vitamins/Supplement regime: _____
_____
_____
_____
_____

Your Lifestyle

□ Alcohol
□ Tobacco
□ Marijuana

□ Drugs
□ Stress
□ Artificial Sweetener

□ Regular Exercise
Type: _____ Frequency: _____
Type: _____ Frequency: _____
Type: _____ Frequency: _____

General Symptoms

□ Poor Appetite
□ Heavy Appetite
□ Strongly like cold drinks
□ Strongly like Hot drinks
□ Recent Weight Gain
□ Recent Weight Loss
□ Bodily Heaviness

□ Poor Sleep
□ Heavy Sleep
□ Dream-disturbed Sleep
□ Sleep Apnea
□ Fatigue
□ Lack of Strength

□ Cold Hands or Feet
□ Poor Circulation
□ Shortness of Breath
□ Fever
□ Chills
□ Night Sweats

□ Sweats Easily
□ Muscle Cramps
□ Vertigo or Dizziness
□ Bleed or Bruise Easily
□ Peculiar taste:
(describe):_____

Head, Eyes, Ears, Nose and Throat

□ Glasses
□ Eye Strain
□ Eye Pain
□ Red Eyes
□ Itchy Eyes
□ Spots in Eyes
□ Poor Vision
□ Blurred Vision
□ Night Blindness

□ Glaucoma
□ Cataracts
□ Teeth Problems
□ Grind Teeth
□ TMJ
□ Facial Pain
□ Gum Problems
□ Lumps in Throat
□ Enlarged Thyroid

□ Excessive Saliva
□ Sinus Problems
□ Excessive Phlegm
□ Color of Phlegm:
_____
□ Recurrent Sore Throat
□ Swollen Glands
□ Dry Mouth
□ Other Head/Neck Problems _____

□ Nose Bleeds
□ Ringing in Ears
□ Poor Hearing
□ Earaches
□ Headaches
□ Migraines
□ Concussions
□ Sores on Lips or Tongue

Respiratory

□ Pneumonia
□ Difficulty Breathing when lying down

□ Shortness of Breath
□ Tight Chest
□ Asthma/Wheezing

□ Cough
Wet or Dry
Thick or Thin

Color of Phlegm:
_____
□ Coughing Blood

Cardiovascular

□ High Blood Pressure
□ Low Blood Pressure
□ Difficulty Breathing

□ Fainting
□ Chest Pain
□ Blood Clots

□ Tachycardia
□ Heart Palpitations
□ Phlebitis

□ Irregular Heartbeat

Gastrointestinal

□ Nausea
□ Vomiting
□ Bloating
□ Gas
□ Hiccups
□ Acid Regurgitation
□ Bad Breath
□ Diarrhea
□ Constipation
□ Laxative Use
□ Black Stools
□ Mucous in Stools
□ Intestinal Pain/Cramping
□ Itchy Anus
□ Burning Anus
□ Rectal Pain
□ Hemorrhoids
□ Anal Fissures

Bowel Movements:
Frequency: _____
Color: _____
Odor: _____
Texture/Form: _____
_____

Musculoskeletal

□ Neck/Shoulder Pain
□ Muscle Pain
□ Upper Back Pain
□ Lower Back Pain
□ Joint Pain
□ Rib Pain
□ Limited Range of Motion
□ Limited Use
□ Other (describe):
_____
_____

Skin and Hair

□ Rashes
□ Hives
□ Ulceration
□ Eczema
□ Psoriasis
□ Acne
□ Dandruff
□ Itching
□ Hair Loss
□ Change in Hair Texture
□ Change in Skin Texture
□ Other Hair/Skin Problems:
_____
_____
_____

Neuropsychological

□ Seizure
□ Numbness
□ Tics
□ Poor Memory
□ Depression
□ Anxiety
□ Irritability
□ Easily Stressed
□ Abuse Survivor
□ Considered/Attempted Suicide
□ Seeing a Therapist
□ Other (specify): _____

Male / Female Genitourinary

□ Pain on Urination
□ Frequent Urination
□ Urgent Urination
□ Blood in Urine
□ Incontinent
□ Incomplete Urination
□ Venereal Disease
□ Benign Prostate Enlargement (BPE)
□ Wake to Urinate
□ Increased Libido
□ Decreased Libido
□ Kidney Stones
□ Impotence
□ Premature Ejaculation
□ Nocturnal Emission
□ Bedwetting

Other Issue: _____

Female/Gynecological

Age Menses Began: _____
Length of Cycle (Day 1 to Day 1) _____
Duration of Flow: _____
Date Last Period Began:

□ Irregular Periods
□ Painful Period
□ Vaginal Odor
□ Vaginal Discharge
Color: _____

Date of Last PAP: _____

□ Clots
□ PMS
□ Breast Lumps

# of Pregnancies: _____
# of Live Births: _____
# of Premature Births: ___
Age of Menopause: _____

Other Issue: _____

Past Medical History
Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

☐ AIDS/HIV	☐ Diabetes	☐ Multiple Sclerosis	☐ Thyroid Disorders
☐ Alcoholism	☐ Emphysema	☐ Mumps	☐ Tuberculosis
☐ Allergies	☐ Epilepsy	☐ Pacemaker	☐ Typhoid Fever
☐ Appendicitis	☐ Goiter	☐ Pleurisy	☐ Ulcers
☐ Arteriosclerosis	☐ Gout	☐ Pneumonia	☐ Venereal Disease
☐ Asthma	☐ Heart Disease	☐ Polio	☐ Whooping Cough
☐ Birth Trauma (Your own birth)	☐ Hepatitis	☐ Rheumatic Fever	☐ Other (specify):
	☐ Herpes	☐ Scarlet Fever	_____
☐ Chicken Pox	☐ High Blood Pressure	☐ Seizures	_____
☐ Cancer	☐ Measles	☐ Stroke	_____
Type: _____			

List all medications you are currently taking.

Medications	**Strength**	**How many per day?**	**For how long?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any substance or medications you are allergic to.

_____

List any major surgeries you have had.

Date Problem

_____
_____
_____

List significant trauma (Auto accident, falls).

_____
_____
_____

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