

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 Coffee Sugar Thirst for Water:
 Low Soft Drinks Salty Food # of Glasses per Day: _____
 Artificial Sweetener

Vitamins/Supplement regime: _____

Your Lifestyle

- Alcohol Drugs Regular Exercise
 Tobacco Stress Type: _____ Frequency: _____
 Marijuana Artificial Sweetener Type: _____ Frequency: _____
Type: _____ Frequency: _____
-

General Symptoms

- Poor Appetite Poor Sleep Cold Hands or Feet Sweats Easily
 Heavy Appetite Heavy Sleep Poor Circulation Muscle Cramps
 Strongly like cold drinks Dream-disturbed Sleep Shortness of Breath Vertigo or Dizziness
 Strongly like Hot drinks Sleep Apnea Fever Bleed or Bruise Easily
 Recent Weight Gain Fatigue Chills Peculiar taste:
 Recent Weight Loss Lack of Strength Night Sweats (describe): _____
 Bodily Heaviness
-

Head, Eyes, Ears, Nose and Throat

- Glasses Glaucoma Excessive Saliva Nose Bleeds
 Eye Strain Cataracts Sinus Problems Ringing in Ears
 Eye Pain Teeth Problems Excessive Phlegm Poor Hearing
 Red Eyes Grind Teeth Color of Phlegm: _____ Earaches
 Itchy Eyes TMJ _____ Headaches
 Spots in Eyes Facial Pain Recurrent Sore Throat Migraines
 Poor Vision Gum Problems Swollen Glands Concussions
 Blurred Vision Lumps in Throat Dry Mouth Sores on Lips or Tongue
 Night Blindness Enlarged Thyroid Other Head/Neck Problems _____
-

Respiratory

- Pneumonia Shortness of Breath Cough Color of Phlegm:
 Difficulty Breathing Tight Chest Wet or Dry _____
when lying down Asthma/Wheezing Thick or Thin Coughing Blood
-

Cardiovascular

- High Blood Pressure Fainting Tachycardia Irregular Heartbeat
 Low Blood Pressure Chest Pain Heart Palpitations
 Difficulty Breathing Blood Clots Phlebitis
-

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Intestinal Pain/Cramping |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Itchy Anus |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Constipation | <input type="checkbox"/> Burning Anus |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Laxative Use | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Acid Regurgitation | <input type="checkbox"/> Mucous in Stools | <input type="checkbox"/> Anal Fissures |

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

Musculoskeletal

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck/Shoulder Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Limited Range of Motion |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Limited Use |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Rib Pain | |

Other (describe):

Skin and Hair

- | | | |
|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in Hair Texture |
| <input type="checkbox"/> Ulceration | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in Skin Texture |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | |

Other Hair/Skin Problems:

Neuropsychological

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Depression | <input type="checkbox"/> Abuse Survivor |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Considered/Attempted Suicide |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Irritability | <input type="checkbox"/> Seeing a Therapist |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Easily Stressed | <input type="checkbox"/> Other (specify): _____ |

Male / Female Genitourinary

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Incontinent | <input type="checkbox"/> Wake to Urinate | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Incomplete Urination | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Premature Ejaculation |
| <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Nocturnal Emission |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Benign Prostate Enlargement (BPE) | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Bedwetting |

Other Issue: _____

Female/Gynecological

- | | | | |
|---|--|---------------------------------------|------------------------------|
| Age Menses Began: _____ | <input type="checkbox"/> Irregular Periods | Date of Last PAP: _____ | # of Pregnancies: _____ |
| Length of Cycle (Day 1 to Day 1) _____ | <input type="checkbox"/> Painful Period | _____ | # of Live Births: _____ |
| Duration of Flow: _____ | <input type="checkbox"/> Vaginal Odor | <input type="checkbox"/> Clots | # of Premature Births: _____ |
| Date Last Period Began: _____ | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> PMS | Age of Menopause: _____ |
| | Color: _____ | <input type="checkbox"/> Breast Lumps | |

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

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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