LONG BEACH COMMUNITY ACUPUNCTURE

New Patient Registration & Health History

Patient Information

Name: _____

Date: _____

Address: _____

City/State/Zip: _____

Birthdate: _____

Gender/Preferred Pronoun: _____

Occupation: _____

Contact Information

Phone number: _____

Email: _____

Emergency Contact

Name: _____

Phone number: _____

Relationship: _____

Who is your primary medical care provider?_____

Is this your first time getting acupuncture? Yes / No

How did you hear about us? _____

Health History

1. What is your primary reason for seeking acupuncture treatment?

_____

When did this start? _____

What makes it better?_____ What makes it worse? _____

Does it interfere with your daily life and/or work? _____

Please rate the intensity of your issue on a scale of 0-10, with 0 as non-existent and 10 as the worst you have experienced. **0-----3-----5-----7-----10**

2. Is there another issue you want to work on with acupuncture?

_____

When did this start? _____

What makes it better?_____ What makes it worse? _____

Does it interfere with your daily life and/or work? _____

Please rate the intensity of your issue on a scale of 0-10, with 0 as non-existent and 10 as the worst you have experienced. **0-----3-----5-----7-----10**

3. Are there any other health concerns you'd like us to know about?

_____

Other health information:

How is your sleep? _____

Do you feel like you have enough energy to get through your day? _____

Do you have any trouble with digestion? _____

How often do you move your bowels?_____ With ease? _____

What medications/supplements do you take? _____

Major illnesses/accidents/surgeries? _____

For those who have a period, when was your last one?_____ Do you have regular or irregular cycles and do you suffer from PMS? _____

Please indicate if you have (or have had) any of the following:

☐Cardiac pacemaker ☐Seizure disorder ☐Bleeding disorder ☐Fainting disorder ☐High blood pressure

☐Believe you are or may be pregnant ☐HIV/AIDS ☐Hepatitis ☐Tuberculosis (TB)

Other: _____