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PATIENT REGISTRATION FORM

Date _____

Patient Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____
 Check box if you want reminder (Call / Text)

Date of Birth _____ Age _____ Sex (M / F) _____ Marital Status (M / S / D / W) _____

Occupation _____ Social Security # _____

Employer _____ Work Phone _____ Drivers License # _____ State _____

Employer Address _____ City _____ State _____ Zip _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name _____ Date of Birth _____

Relationship to Patient (please check): () Self, () Spouse, () Parent, or Other () _____

Address _____ Phone Number _____
(Street) (City/State/Zip)

Occupation _____

Employer Name _____ Work Phone _____ Drivers License # _____ State _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact

Name _____ Address _____
(Street) (City/State/Zip)

Home Phone _____ Work Phone _____ Relationship _____

Insurance Information (Please have I.D.)

Insurance Company Name _____ I.D. Number _____

Address _____ Group Number _____
(Street or P.O. Box) (City/State/Zip)

Policy Holder Name _____ Effective Date _____

Policy Holder's Social Security # _____ Sex (M / F) _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Lifeline Acupuncture & Herbs Clinic. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

Medical History Form

Name _____ DOB _____ Date _____

MEDICAL HISTORY

What medical conditions do you have? Select all that apply, or write in if not listed:

Diabetes _____ High Blood Pressure _____ Thyroid Disorder _____ Heart Disease _____ High Cholesterol _____
Arthritis _____ Cancer _____ Kidney Disease _____ Glaucoma _____ Asthma _____ Allergies _____
Migraine Headache _____ Anemia _____ Obesity _____ Acid Reflux _____

Other: _____

Female Only Age of first menstrual cycle _____

Are you pregnant? _____ (Y/N) Is it possible that you are pregnant? _____ (Y/N)

Date of last period _____ Do you have a history of irregular menstrual cycles? _____ (Y/N)

Number pregnancies _____ Number births _____ Number Premature births _____ Number Miscarriages _____

Are you currently on birth control? _____ (Y/N) *If yes, What type / name?* _____

MEDICATION: Please list all medications you care now taking

Medication _____ Prescribed by _____

Medication _____ Prescribed by _____

Medication _____ Prescribed by _____

Surgeries (operations) Please list all you had in the past 10 years

_____ Year _____

_____ Year _____

_____ Year _____

ALLERGIES (Allergic reactions to medication, foods: Please list the TYPE OF REACTION)

Medication / Foods Allergy

Reaction

General

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Heavy sleep |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tremors | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Cold abdomen |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Cravings | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Sudden energy drop at _____ time | | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Strong thirst (Cold/Hot) |

Skin and Hair

- | | | | |
|--|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Purpura | <input type="checkbox"/> Boil | <input type="checkbox"/> Change in hair, skin texture | |
| <input type="checkbox"/> Tumors, Masses or Lumps (where) _____ | | | |
| <input type="checkbox"/> Other hair or skin problems _____ | | | |

Head and Neck

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Copious saliva |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Tooth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Recurrent sore throats _____/months | |
| <input type="checkbox"/> Sore on lips or tongue | <input type="checkbox"/> Headaches/Migraines (where/when) _____ | | |
| <input type="checkbox"/> Other head or neck problems _____ | | | |

Cardiovascular

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing | |
| <input type="checkbox"/> Other C/V problems _____ | | | |

Respiratory

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> C.O.P.D | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Tight chest (how often) _____ | |
| <input type="checkbox"/> Production of phlegm: Amt./Freq.: _____ Color: _____ Consistency: _____ | | | |
| <input type="checkbox"/> Other lung problems _____ | | | |

Gastrointestinal

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bowel movement: |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stool | _____ Frequency |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids | _____ Color |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Sensitive abdomen | _____ Odor |
| <input type="checkbox"/> Pain or cramps | <input type="checkbox"/> Laxative use. Frequency of use: _____ | | _____ Texture/form |
| <input type="checkbox"/> Other G.I. problems _____ | | | |

Musculoskeletal (Draw picture next page)

- | | | | |
|---|---------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Back pain | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Other joint or bone problems _____ | | | |

Neuropsychological

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Treated for emotional problems | | <input type="checkbox"/> Considered/Attempted suicide | |
| <input type="checkbox"/> Other neurological problems _____ | | | |

SOCIAL

How much do you smoke? _____ Pack/Day How long? _____

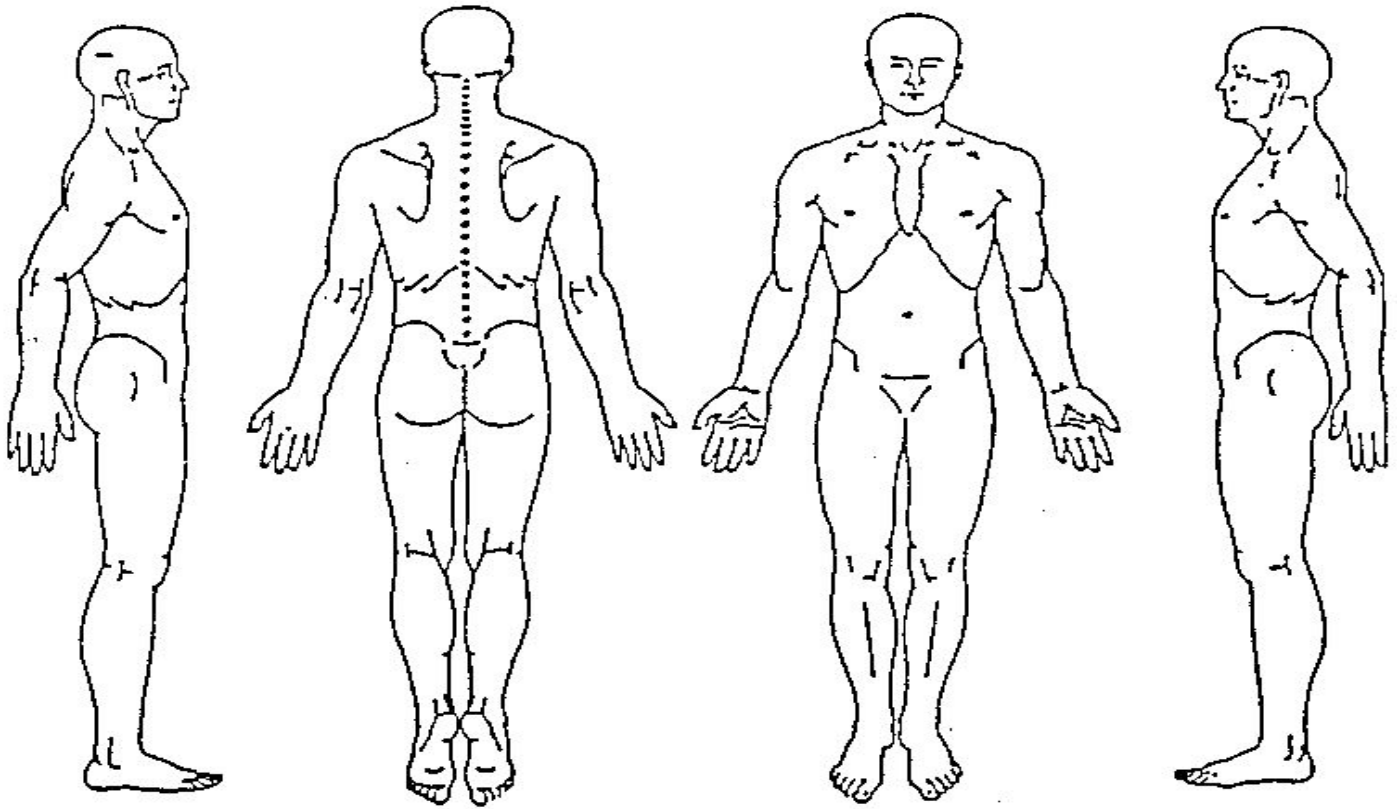
How much alcohol (including beer) do you drink in a week? _____

Have you used or currently use recreational drugs? _____ (Y/N) *If yes how long* _____

What is your major complaint(s) and symptom(s):

Please indicate any painful or distressed areas by circling the area

A = Ache P = Pins & Needles B = Burning S = Stabbing N = Numbness O = Others



General location and type of pain _____

When did you first notice the symptom(s)? _____

Have you given a diagnosis for this problem? *If so, what?* _____

Has this condition been treated before? _____ (Y/N) When _____ By Whom _____

Any Family history of this condition _____

Were you referred by another physician? _____ (Y/N) *If yes, Dr.'s Name* _____

If no, how did you hear about us? _____

Signature _____

Date _____