LIFELINE
Acupuncture & Herbs Clinic

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PATIENT REGISTRATION FORM

Date ____________

Patient Name ______________________ Phone Number ______________________

☐ *Check box* if you want reminder (Call / Text)

Address ______________________ City ____________ State ________ Zip ________

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

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo
☐ Cold hands ☐ Cold feet ☐ Night sweats ☐ Cold abdomen
☐ Fever ☐ Cravings ☐ Poor coordination ☐ Sweat easily
☐ Chills ☐ Localized weakness ☐ Peculiar tastes/smells ☐ Change in appetite
☐ Sudden energy drop at ______time ☐ Bleed or bruise easily ☐ Strong thirst (Cold/Hot)

Skin and Hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair
☐ Purpura ☐ Boil ☐ Change in hair, skin texture
☐ Tumors, Masses or Lumps (where) _______________
☐ Other hair or skin problems ____

Head and Neck

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

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pains ☐ Irregular heart beat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing
☐ Other C/V problems ____

Respiratory

☐ Asthma ☐ Bronchitis ☐ C.O.P.D ☐ Pneumonia
☐ Cough ☐ Coughing blood ☐ Tight chest (how often) ________________________
☐ Production of phlegm: Amt./Freq.: ____________ Color: ____________ Consistency: ____________
☐ Other lung problems ____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Bowel movement:
☐ Gas ☐ Belching ☐ Black stool _____ Frequency
☐ Bad breath ☐ Rectal pain ☐ Hemorrhoids _____ Color
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____ Odor
☐ Pain or cramps ☐ Laxative use. Frequency of use: _______________ _____ Texture/form
☐ Other G.I. problems ____

Musculoskeletal (Draw picture next page)

☐ Neck pain ☐ Muscle pains ☐ Back pain ☐ Joint pain
☐ Other joint or bone problems ____

Neuropsychological

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion
☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed
☐ Treated for emotional problems ☐ Considered/Attempted suicide
☐ 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____________________

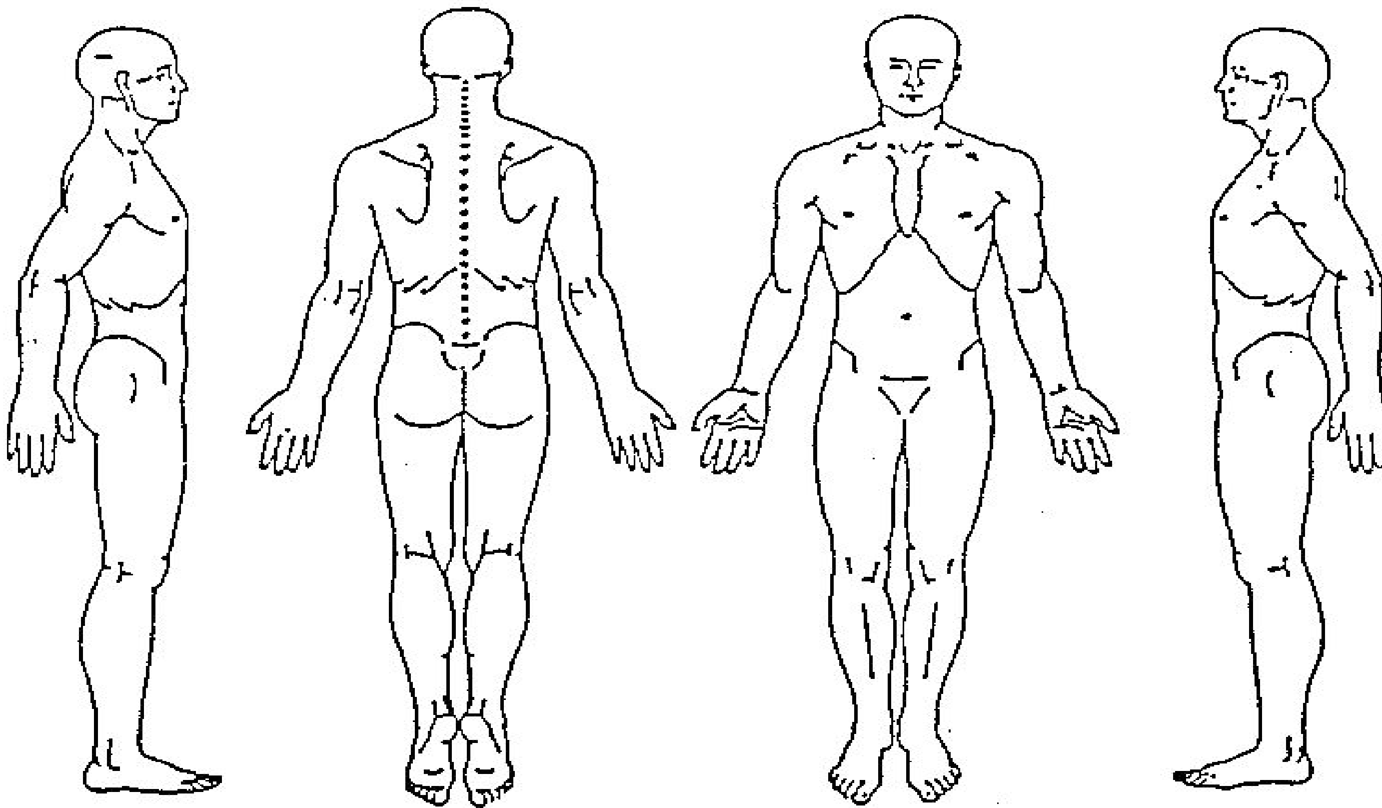
What is your major complaint(s) and symptom(s):

____

____

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** ________________________