Patient Registration Form

Date:	☐ Female ☐ Male	☐ Date of Birth:	
Name	Last)	First)	
Address			
Phone #	☐**Cell** ☐**Home**	Emergency Contact	
Occupation		☐ single ☐ Married ☐ Divorced ☐ Widowed ☐ separated	
Email			
Weight	_____ **lbs (**_____**kg)**	Height	_____ **ft**_____ **in (**_____**cm)**

What is your main complain(s)? _____

How it happened? _____

When did this condition begin? (onset date) _____

If the discomfort radiates, where does travel to? _____

Severity of your pain: (0 = no pain / 10 = severe pain) [0 1 2 3 4 5 6 7 8 9 10]

Frequency of pain: ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%) ☐ On and off ☐ Random ☐ Recurring

How would you describe your pain? (check all the apply)

☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp
☐ Stiffness ☐ Throbbing ☐ Tightness ☐ Shock like ☐ Tingling
☐ Stabbing ☐ Tearing ☐ Miserable ☐ Shooting ☐ Deep/penetrating
☐ Pins & needles ☐ Intolerable ☐ Spasm ☐ Other _____

Symptom relieved by?

☐ Cold packs ☐ exercise ☐ heat pack ☐ massage ☐ nothing
☐ rest ☐ stretching ☐ Chiropractic ☐ Acupuncture ☐ Physical Therapy ☐ Other _____

What aggravates the symptoms? _____

Previous episodes? ☐ Yes ☐ No if yes, how long ago? _____

What treatment have you received for the above conditions(s)?

☐ Surgery ☐ Medications ☐ Physical Therapy ☐ Chiropractic ☐ Massage ☐ Injections
☐ MRI ☐ X-Ray ☐ CT scan ☐ Others: _____

Are you currently receiving any treatments(S)? ☐ No ☐ Yes : _____

Activity of daily living most affected?

☐ Sleeping ☐ Walking ☐ Driving ☐ Self-care (washing, dressing, grooming, etc) ☐ Others: _____

Female Patient) Are you currently pregnant? ☐ No ☐ Yes : If yes, how many month?_____

Who can we thank for referring you to our clinic?

☐ Yelp ☐ Google ☐ Friends/Family ☐ Health Insurance ☐ etc: _____

Primary Insurance (If you have an health insurance, give us Insurance Card & your ID for verification)

Insurance Company_____

Secondary Insurance (☐ Check her if you do not have Secondary Insurance)

Insurance Company _____

Systems Review (check all symptoms you had/have)

Musculoskeletal: ☐ None

Had Have				
☐ ☐ Neck pain	☐ ☐ Back problems	☐ ☐ Shoulder problems	☐ ☐ Elbow/wrist pain	☐ ☐ Hip disorders
☐ ☐ Knee injuries	☐ ☐ Foot/ankle pain	☐ ☐ Poor posture	☐ ☐ Arthritis	☐ ☐ Osteoporosis
☐ ☐ Scoliosis	☐ ☐ TMJ issues	☐ ☐ Others _____		

Neurological: □ None

Had Have
□ □ Anxiety | □ □ Depression | □ □ Difficulty concentrating | □ □ Headache | □ □ Numbness
□ □ Sleeping issues | □ □ Memory issues | □ □ Pins and needles | □ □ Weak muscles | □ □ Stroke
□ □ Vomiting | □ □ Nausea | □ □ Epilepsy or seizures | □ □ Loss of smell or taste | □ □ Dizziness
□ □ Temporary loss of vision, smell or hearing | □ □ Others _____

Head & ENT: □ **None**

Had Have
□ □ Cataracts | □ □ Sore throat | □ □ Blurred or double vision | □ □ Dental problem | □ □ Eye problem
□ □ Glaucoma | □ □ Hoarseness | □ □ Difficulty swallowing | □ □ Gum problem | □ □ TMJ problems
□ □ Migraines | □ □ Ring in the ears | □ □ Eye glasses or lenses | □ □ Ear or hearing problem | □ □ Swollen lymph nodes
□ □ Nose congestion or sinus trouble | □ □ Others _____

Cardiovascular: □ **None**

Had Have
□ □ Heart attack | □ □ difficult breathing | □ □ High blood pressure | □ □ High cholesterol | □ □ Palpitations
□ □ Leg edema | □ □ Varicose veins | □ □ Low blood pressure | □ □ Congenital heart defects
□ □ Chest pain or tightness | □ □ Coronary artery disease | □ □ Others _____

Respiratory: □ **None**

Had Have
□ □ Apnea | □ □ Asthma | □ □ Emphysema | □ □ Hay fever | □ □ Pneumonia
□ □ Snoring issue | □ □ Tuberculosis | □ □ Blood in sputum | □ □ Shortness of breath | □ □ Wheezing
□ □ Persistent cough | □ □ Others _____

Gastrointestinal: □ **None**

Had Have
□ □ Colitis | □ □ Heartburn | □ □ Changes in bowl habits | □ □ Constipation | □ □ IBS
□ □ Hemorrhoids | □ □ Crohn's disease | □ □ Colon cancer or polyps | □ □ Gastric reflux | □ □ Liver disease
□ □ Ulcer | □ □ Nausea/vomiting | □ □ Pancreatitis | □ □ Severe diarrhea | □ □ Food sensitivities
□ □ Bloating | □ □ Abdominal pain | □ □ Black or bloody stool | □ □ Others _____

Genitourinary: □ **None**

Had Have
□ □ Incontinence | □ □ Kidney stones | □ □ Blood in the urine | □ □ Sexual dysfunction | □ □ Urgency
□ □ Urinary infection | □ □ Painful or frequent urination | □ □ Others _____

Endocrine: □ **None**

Had Have
□ □ Diabetes | □ □ Excessive thirst | □ □ Hyperparathyroidism | □ □ Hyperthyroidism | □ □ Purple striae
□ □ Polydipsia | □ □ Polyuria | □ □ Hot or cold all the time | □ □ Hypothyroidism | □ □ Other _____

Derma/Hemo: □ **None**

Had Have
□ □ Skin cancer | □ □ Eczema | □ □ Excessive hair loss | □ □ Psoriasis | □ □ Albinism
□ □ Easy bruising | □ □ Blood in stool | □ □ Others _____

Female: Menstruation □ Regular □ Irregular Cycle : Every _____days / Lasts _____days

Blood Amount: □ Heavy □ Normal □ Scanty □ Clear **Color**: □ Bright Red □ Dark Red □ Brown

Leucorrhea : □heavy □thick □yellow □foul smell □scanty □thin □clear **How many?** Children ___ Miscarriage ___ Abortion ___ C-section___

Women's Health

Had Have
□ □ Fibroids | □ □ Ovarian Cysts | □ □ Endometriosis | □ □ PCOS | □ □ An-Ovulation
□ □ Blocked Tubes | □ □ Pelvic Inflammation

Past Health History

Surgery / Hospitalization History

Year	Surgeries / Hospitalizations	Complications

Medications: (Include antibiotics, blood thinners, insulin, heart mediations, aspirin, and any other over-the-counter medications. Include vitamin, mineral, and herb supplements.)

Current Medication(s)	Dose	Frequency

Allergies: Yes □ No □ if yes, please list: _____

Past Illnesses: □ None

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
□	□	AIDS/HIV	□	□	Bronchitis	□	□	Emphysema	□	□	Cancer/tumor	□	□	Hernia
□	□	Alcoholism	□	□	Diabetes	□	□	Kidney disease	□	□	Osteoporosis	□	□	Pacemaker
□	□	Anemia	□	□	Hepatitis	□	□	Liver disease	□	□	Multiple sclerosis	□	□	Polio
□	□	Venereal disease	□	□	Others _____									

Past Accidents or Trauma: □ None

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
□	□	Slip/fall	□	□	Fracture	□	□	Bicycle accident	□	□	Motorcycle accident	□	□	Pedestrian
□	□	Car accident	□	□	Others _____									

Family History: (examples: diabetes, arthritis, cancer, hypertension, stoke, seizures, gout, blood clots kidney, liver, heart diseases)

Relative	Age (if living)	State of health	Illnesses	Age at death	Cause of death
Mother	_____	(Good Poor)	_____	_____	(Natural Illness)
Father	_____	(Good Poor)	_____	_____	(Natural Illness)
Sibling 1 (M F)	_____	(Good Poor)	_____	_____	(Natural Illness)
Sibling 2 (M F)	_____	(Good Poor)	_____	_____	(Natural Illness)
Sibling 3 (M F)	_____	(Good Poor)	_____	_____	(Natural Illness)

Work History:

□ Full time □ Part time □ Homemaker □ Retired □ Student □ Unemployed □ Fully or Partially disabled

How many hours do you work per week? (average) _____

□ Mostly sitting □ Standing □ Walking □ Light labor □ Moderate labor □ Heavy labor □ Sedentary

□ Computer □ Repetitive □ Telephone □ Difficult □ Enjoyable □ Relaxed □ Stressful

Social History: (Your health habits and stress levels)

Alcohol use □ Never □ Social drinker □ Light drinker □ Moderate drinker □ Heavy drinker □ An Alcoholic □ Recovering Alcoholic

Tobacco use □ Never □ Social smoker □ Light smoker □ Every day smoker □ Heavy drinker □ Ex-smoker □ Unknown

Coffee use □ Never □ 1 cup in the morning □ 2-4 cups every day □ 5 or more cups every day

Water intake How much? _____ Pain relievers □ None How much? _____

Soft drinks How much? _____ Recreational drugs □ None How much? _____

Exercising □ Never □ Every day □ Every other day □ Few times a week □ Once a week

What kinds of exercise do you do? _____

Diet/nutrition □ Controlled, restricted, balanced diet □ Diabetic diet □ Gluten free diet □ Vegetarian, vegan, raw food diet

How many meals a day? _____

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, alternative medicine, herbs and other substances by a licensed acupuncturist in this clinic.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, numbness, minor bleeding, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to acupuncture treatment. Other unusual but rare risks include lung or organ puncture, nerve damage, and spontaneous miscarriage. I understand that no guarantees concerning its use and effects are given to me and that I may stop acupuncture treatment at any time. **Initial:** _____.

Moxibustion: I understand that if I receive moxibustion (heat therapy) as part of therapy, there is a risk of burning with the use of direct moxibustion burning and/or scarring may result from its use. I understand that I may refuse either of these therapies. **Initial:** _____.

Cupping: I understand that if I receive cupping as part of therapy, there is a risk of tenderness, redness, bruising, blistering, and/or scarring. I understand that I may refuse this therapy. **Initial:** _____.

Herbs & Supplements: I understand that herbs and supplements may be recommended to me to treat bodily dysfunctions, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movements, abdominal pain/discomfort, nausea/vomiting, rashes and possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I will suspend taking them and call my acupuncturist as soon as possible. **Initial:** _____.

Electro Acupuncture: I understand that I may be asked to have electro acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. **Initial:** _____.

Nutritional and Lifestyle Counseling: I understand that the practitioner neither claims nor implies that any instruction, advice, recommendations, services, or herbal/nutritional products the practitioner provides or recommends will cure, treat, prevent or mitigate any disease condition, but are provided solely for the purpose of nourishing and strengthening the natural function of the various body organs and systems so that they may have a greater capacity to heal themselves. I understand that the practitioner believes many diseases are related to unresolved emotional conflicts. I understand that counseling or assistance offered in this area is done on a spiritual basis and does not replace licensed psychiatric care or professional counseling. I request the advice and assistance of this practitioner in helping me to learn what I can do to improve my health and fitness. I request this information and any products or services that may attend it as my right to Freedom of Choice in Medicine and Health care retained by me under the Ninth Amendment to the U.S. Constitution, of certain rights, shall not be construed to deny or disparage others retained by this person. **Initial:** _____.

I understand that the acupuncture practitioner must be advised if I have a **pacemaker, cardiac condition, bleeding disorder, history of seizures, on blood thinners** (Coumadin, Warfarin, etc.), or if I am or may be **pregnant**. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. If I have not already done so, I agree to consult with a medical doctor for any serious or life threatening disease or condition either for myself or those under my guardianship.

I have carefully read and understand all information contained within this consent to treatment form and I am fully aware of what I am signing.

Patient Signature: _____ **Date:** _____

Guardian's Signature: _____ **Date:** _____

Cancellation, Missed Appointment and Late Arrival Policy

We do our best to take care of each patient in their scheduled appointment time. Please review our policy so that you can help us in providing the best care possible. Reminder text messages are sent out as a courtesy to our patients. Please bear in mind that you are still responsible for the appointment.

Cancellations: If you are unable to keep your scheduled appointment, please give us **24 hour notice**. Our office phone number is 714-202-2541. If you reach our voicemail after hours, please leave a detailed message for us. If you would like to reschedule your appointment, please leave a phone number and we will contact you as soon as possible.

Missed Appointment/No Show/Late Arrivals: We understand that emergencies and inclement weather happen, and we would like for you to let us know if something prevents you from being here. However, appointments that are missed without notice (no call/no show), are more than 15 minutes late (without notice), or same-day cancellations (except in emergency cases) will be subject to the following:

- **1st & 2nd missed appointment**: A reminder of the policy will be issued to the patient.
- **3rd missed appointment**: **There will be a $20 fee,** which the patient will be held responsible for. This fee will be added to your next visit.

I have read the policy above. I understand and agree to abide by the listed terms.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Financial Policy

[Personal Injury Case]

Patient who doesn't disclose or knowingly not telling the truth about personal injury (PI) case and received treatment as regular self-pay patient in purpose of getting more settlement for themselves, will be billed again as personal injury using correct fee schedule like should have been done in the first place. **When we treated the patient as regular patient and request for our medical record to be used in PI case or in ligation, patient need to sign doctor's lien, agreement to pay off the whole PI bill, and authorization to release medical record before receiving the medical record.**

[Responsibility for Payment]

As courtesy to you, we will gladly submit your charges to your insurance company; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

I have read the policy above. I understand and agree to abide by the listed terms.

Patient Signature: _____ **Date:** _____