BALANCED HEALTH ACUPUNCTURE : **Registration & Health History** **Date ___ /____ /_____**

1 PATIENT INFORMATION

Last Name	
First Name	
Address	
City	State
Zip	Sex ☐ Male ☐ Female
Age	Birthdate
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Single ☐ Partnered	
Patient Employer / School	
Occupation	
Employer / School Address	

2 CONTACT INFORMATION

Cell Phone:	
Home Phone:	
Work Phone:	
Email:	
EMERGENCY CONTACT	
Name	Relationship
Work Phone	Cell Phone

3 How did you hear about us?

☐ Citysearch
☐ Google
☐ Other: _____

4 PATIENT CONDITION

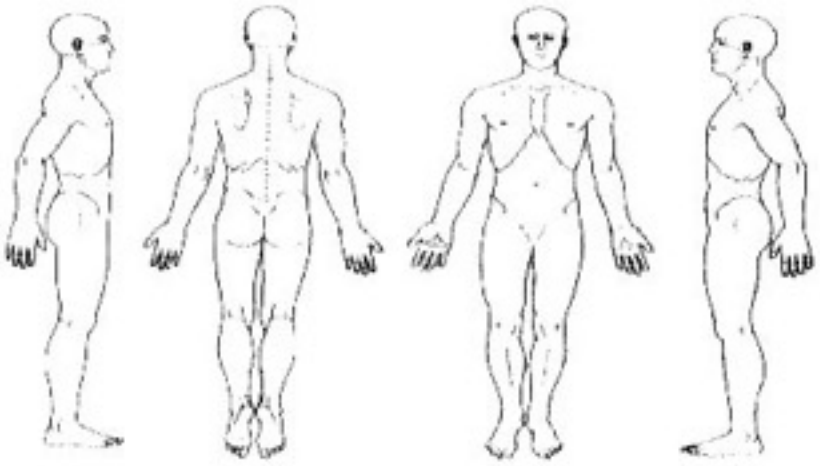
1. Reason for Visit

2. When did your symptoms appear?

_____

3. How did your symptoms begin?

_____



4. Mark an **X** on the picture where your symptoms appear (if applicable).

5. How are your symptoms changing?
☐ Getting Better ☐ Not Changing
☐ Getting Worse ☐ Not Sure

6. What tests have been performed for your condition?
☐ X-Rays *date*: _____
☐ CT Scan *date*: _____
☐ MRI *date*: _____
☐ Other *date*: _____

7. Do symptoms interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other _____

8. What treatment have you already received for your condition? ☐ None ☐ Medications ☐ Chiropractic
☐ Physical Therapy ☐ Acupuncture ☐ Surgery ☐ Other: _____

9. Secondary Complaints _____

10. Treatment for Other Conditions: ☐ No ☐ Yes (Please, explain) _____

11. In general, would you say your overall health right now is : ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

5 HEALTH HISTORY

• Place check to indicate if you have had any of the following:

☐ AIDS / HIV ☐ Cancer ☐ Hypertension ☐ Sexually transmitted
☐ Allergies _____ ☐ Diabetes ☐ Miscarriage diseases _____
☐ Anemia ☐ Epilepsy ☐ Nervous Breakdown ☐ Pacemaker
☐ Asthma
☐ Bleeding Disorder ☐ Hepatitis B
☐ Heart Disease ☐ Stroke
☐ Tuberculosis ☐ Artificial Joints
☐ Other_____

• **Past surgeries** (indicate type/year) ☐ None ☐ Yes

_____

• **Have you been advised to have surgery which was not done?** ☐ No ☐ Yes _____

• **Any familial disease tendency of which you are aware? (ie. Diabetes, cancer)** ☐ No ☐ Yes

_____

• **For women only** Check to indicate, if you are: ☐ Pregnant ☐ Nursing Child ☐ Have Uterine Fibroids

LIFESTYLE HABITS

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking (# packs / day _____)
- ☐ Alcohol (# drinks / day _____)
- ☐ Coffee / Caffeine Drinks (# cups / day _____)
- ☐ High Stress Levels (# reason _____)
- ☐ Non-medical drugs (# type _____)

MEDICATIONS / VITAMINS / HERBAL SUPPLEMENTS (Taken with last 2 months including over-the-counter drugs)

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last checkup

6 SIGNATURE

PATIENT AFFIRMATION

I ,the patient, have been advised by the acupuncturist), to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

PRIVACY POLICY

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practice.

This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file to give the opportunity to sign the new form.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. **I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges**.

CANCELLATION POLICY: I agree to provide at least 24 hours notice of appointment cancellations and am responsible for the full cost of treatment if I do not provide sufficient notice of cancellation of an appointment.

CHECK PAYMENTS: I understand that personal check payments returned due to insufficient funds are subject to a $15 per check penalty charge.

I have read, understood and agree to the terms detailed in the above patient affirmation, privacy policy and financial agreement. To the best of my knowledge, the information I've provided on this form is complete and correct.

X _____ _____

Signature Date

Relationship to patient:

☐ Self

☐ Parent

☐ Guardian