Healing Ocean Community Acupuncture

Registration and Health History

Patient Information	**Contact Information**
Date _____ Name _____ Address_____ City, State Zip_____ Age_____ Birthdate_____ Occupation_____ Physician_____ Physician phone number_____ How did you hear about us?_____ _____	Home phone_____ Work phone_____ Other/cell phone_____ Email_____ Another person to contact if needed: Name_____ Relationship_____ Home phone_____ Work phone_____

Current Condition	
What are your primary reasons for treatment? 1-_____ 2-_____ 3-_____ How is your sleep?_____ _____ How is your digestion?_____ _____ Do you easily feel hot or cold?_____ How is your energy?_____ List any medications or food supplements you are taking:	If in pain, describe its location. _____ _____ Describe the nature of the pain (ie dull, throbbing, sharp,) _____ Is it constant?_____ When is it worst?_____ _____ Does it keep you from any activities? _____ On a scale of 1-10 where 10 is unbearable pain and 1 is no pain. How are you now?_____ How is it at worst?_____ How is it generally?_____

Health History

Check any symptoms below that you currently have or have had in the past year

Cough	Poor appetite	Bruise easily	Red/itchy eyes
Dry mouth	Loose stools	Nosebleeds	Blurry vision
Phlegm in throat	Belching	Rashes/hives	Sensitive to light
Nasal congestion	Nausea	Blood in stool	Muscle cramps
Chills	Vomiting	Blood in urine	Twitching muscles
Fever	Constipation	Painful urination	Numbness/tingling
Muscle aches	Ravenous hunger	Burning urination	Spasms
Joint pains	Acid reflux	Frequent urination	Migraines/headaches
Hayfever	Bloating	Night sweats	Irritable/easily angered
Asthma	Abdominal pain	Unusual day sweat	Anxiety/nervousness
Short of breath	Fatigue	Heart palpitations	Depression/blues/weepy
Bronchitis	Hemorrhoids	Memory problems	Excessive worry
Wheezing	Mucus in stools	Chest pains	Excessive fear
Skin problems	Dizziness	Difficulty concentrating	Low libido
Allergies	Ringing in ears	Lower back pain	Knee problems

For Men Only:

Erection difficulties	Penis discharge	Prostate trouble

For Women Only:

Bleeding between periods	Clots in menses	Excessive menstrual flow
Extreme menstrual pain	Irregular cycle	PMS
Menopausal symptoms	Previous miscarriage	Scanty menstrual flow

Could you be pregnant?_____

Have you ever had:

Tuberculosis	Mononucleosis	AIDS/HIV	Hepatitis

Check illnesses that have occurred in blood relatives:

Diabetes	High blood pressure	Cancer	Heart disease
Thyroid problems	Arthritis	Kidney disease	Mental illness

Signature

The information on this form is correct to the best of my knowledge.

Signature_____Date_____