Patient Control # (Office Use):_____

PATIENT REGISTRATION FORM

Name	(First): (Middle): (Last):			
DOB (mm/dd/yy)		**Phone NO.**	(home):	
			(cell):	
Mailing Address			**Zip code**	
E-mail			**Occupation**	
Emergency Contact	**Name**			
	Cell Phone		**Relationship**	

Please describe your main complaints in order of importance:

	Condition:	**For how long?**	**Past treatments:**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Please check all of the following that apply to you:

__ Alcohol/Drug Dependence	__ Frequent Urination	__ Prostate Problems
__ Abnormal Menstruation	__ Headache	__ Sinusitis
__ Allergies	__ Heart Attack	__ Stroke
__ Angina	__ Heartburn/Indigestion	__ Tobacco Use
__ Arthritis/Rheumatoid Arthritis	__ Hepatitis	__ Thyroid Disease
__ Anxiety/Depression	__ High Blood Pressure	__ Tinnitus
__ Asthma	__ HIV	__ Weight Loss
__ Blood Disorder	__ Insomnia	
__ Brest Lumps	__ Kidney Disease	
__ Cancer/Tumor	__ Liver Problems	Other: _____
__ Convulsions/Seizures	__ Nausea	_____
__ Diabetes	__ Night Sweats	_____
__ Diarrhea/Constipation	__ Osteoporosis	
__ Excessive Thirst	__ Pacemaker	
__ Fainting/Dizziness	__ Palpitation/Arrhythmia	
__ Fatigue	__ Peptic Ulcer	
__ Fever	__ Pregnant, #Weeks___	

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Please list the medicines, herbs or vitamins you are using:
Please list the surgeries or major illness you had:
Disclaimer: By signing below, I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the practitioner when I have changes in my health condition. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician, Insurance Company or Family Members, therefore, I give the authorization to my practitioner of acupuncture services to release my medical information to my Primary Care Physician, Insurance Company or Family Members if necessary.

Signature:		**Date:**	