Nam Hoa Acupuncture

160 Macgregor Pines Dr., suite 310B
Cary, NC 27511

Patient Registration Form

Date: _____

Name: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____State: _____Zip Code: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Physician / Primary Health Care Provider: _____

Telephone: _____

Do We Have Permission to Consult with your Primary Provider? ___No ___Yes

In Case of Emergency, Please Notify:

Name: _____ Phone: _____

Relationship To Patient: _____

Reason for Visit

Primary reason for your visit today? _____

_____

Has this condition been diagnosed by a physician or other provider?

☐ No ☐ Yes. Diagnos(es): _____

Are you being treated for this condition by anyone else? ☐ No ☐ Yes

If Yes, what is the treatment? _____

How long have you had this condition? _____

Personal Health History

Your general health as a child: ☐ Excellent ☐ Good ☐ Average ☐ Poor

Did you feel safe and nurtured as a child? ☐ Always ☐ Sometimes ☐ Never

Check all the illnesses or conditions which you currently have or have had in the past:

☐ AIDS/HIV	☐ Eating disorders	☐ Kidney Disease	☐ Rheumatic Fever
☐ Alcoholism	☐ Epilepsy	☐ Measles	☐ Scarlet Fever
☐ Allergies	☐ Glaucoma	☐ Meningitis	☐ STDs/STIs
☐ Antibiotic Use	☐ Heart Disease	☐ Mental Illness	☐ Stroke
☐ Asthma	☐ Hepatitis	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bleeding Easily	☐ High Blood Pressure	☐ Mumps	☐ Typhoid Fever
☐ Cancer: _____	☐ High Fevers	☐ Obesity	☐ Ulcers
☐ Chicken Pox	☐ Hyperthyroidism	☐ Pneumonia	☐ Vascular Disease
☐ Diabetes	☐ Hypothyroidism	☐ Polio	
☐ Drug Abuse	☐ Jaundice	☐ Others: _____	

Do you have a pacemaker? ☐ Yes ☐ No

Do you have a history of seizures? ☐ Yes ☐ No

Are you currently having any infectious disease? ☐ Yes ☐ No ☐ Unsure

If Yes, please identify: ☐ AIDS/HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Flu/cold

☐ Streptococcus ☐ Mononucleosis ☐ Tuberculosis ☐ Other: _____

Known or suspected allergies: _____

Family Health History

Check any condition that have occurred to any of your blood relatives:

☐ Alcoholism	☐ Cancer	☐ Epilepsy	☐ Mental Illness
☐ Allergies	☐ Cardiovascular Disease	☐ High Blood Pressure	☐ Obesity

☐ Bleed Easily ☐ Diabetes ☐ Kidney Disease ☐ Stroke

☐ Other: _____

Medications

Please list any medications, supplements and vitamins that you're currently taking

Name	Reason for taking	For how long	Dosage	Frequency

Lifestyle

How would you rate these areas of your health in the past month

Energy: ☐ Excellent ☐ Fair ☐ Poor Comments: _____

Sleep: ☐ Excellent ☐ Fair ☐ Poor Comments: _____

Digestion: ☐ Excellent ☐ Fair ☐ Poor Comments: _____

Appetite: ☐ Excellent ☐ Fair ☐ Poor Comments: _____

Bowel Movements: ☐ Excellent ☐ Fair ☐ Poor Frequency: _____

Do they feel complete? ☐ Yes ☐ No Comments: _____

Stools: ☐ Loose ☐ Formed ☐ Hard to pass ☐ Watery

Color of your stools: _____ Blood in stools? ☐ Yes ☐ No

Urination: ☐ Excellent ☐ Fair ☐ Poor Comments: _____

Frequency: _____ Color of urine: _____

Painful urination? ☐ Yes ☐ No

Do you wake up to urinate at night? ☐ Yes ☐ No How often? _____

Libido: ☐ Excellent ☐ Fair ☐ Poor Comments: _____

Emotional wellbeing: ☐ Excellent ☐ Fair ☐ Poor Comments: _____

Do you exercise? ☐ Daily ☐ Sometimes ☐ Rarely

Food/Drink

Are you on any special diet? ☐ Yes ☐ No If Yes, please specify: _____

Your recent food cravings: _____ At any specific time? _____

Daily water intake: _____

How often do you consume these beverages?

Coffee: _____ Tea: _____

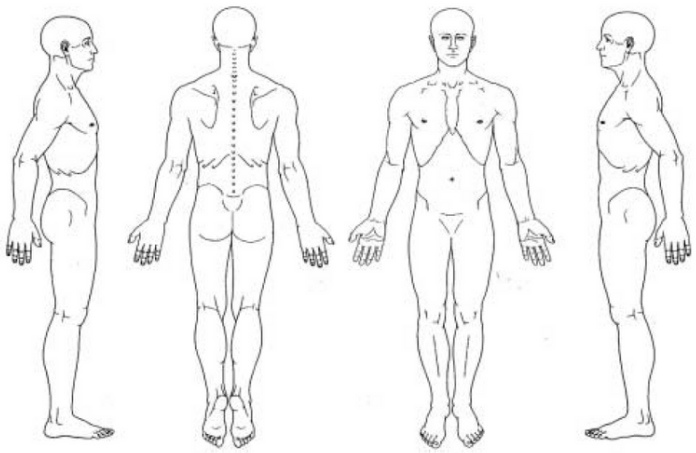
Soda: _____

Alcohol: _____

Do you use tobacco? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Pain



Please mark X on the location(s) of your pain.

How long have you had this pain?_____

_____

Please describe the onset of the pain.

_____

_____

_____

Please rate your pain on a scale of 1 to 10.

1 2 3 4 5 6 7 8 9 10

How does your pain feel? ☐ Dull ☐ Sharp ☐ Stabbing ☐ Cramping ☐ Burning

☐ Constant ☐ Comes and Goes ☐ Fixed ☐ Moves Around

What helps the pain? ☐ Ice ☐ Heat ☐ Movement ☐ Rest ☐ Pressure ☐ Moisture

☐ Massage ☐ Nothing ☐ Other: _____

What aggravates the pain? ☐ Ice ☐ Heat ☐ Movement ☐ Rest ☐ Pressure ☐ Stress

☐ Nothing ☐ Other: _____