



BERKELEY ACUPUNCTURE PROJECT

of California, a 501(c)(3) non-profit organization

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New Patient Registration and Health Questionnaire

Patient Information	Contact Information
Date of First Visit: _____ Name: _____ Address: _____ City State Zip: _____ Age: _____ Birth Date: ____/____/____ Pronoun: She He They <i>other</i> : _____ Occupation: _____ Primary physician: _____	Best phone # _____ Alternate phone # _____ Email: _____ Another person we may contact in case of emergency: Name/Relationship/Phone _____ _____ How did you hear about us? _____ Are you new to acupuncture? Yes ___ No ___
Health Information	
What are your primary concerns/complaints? 1) _____ Date started: _____ Severity: _____ 2) _____ Date started: _____ Severity: _____ 3) _____ Date started: _____ Severity: _____ How is your sleep? _____ How is your energy level? _____ How is your digestion? _____ _____ List medications, supplements, or herbs you are taking: _____ _____ Are you taking blood thinners? Yes ___ No ___ List serious accidents or surgeries: _____ _____ Are you pregnant? Yes ___ No ___ _____ wks Are you interested in taking Chinese Herbs? Yes ___ No ___ Maybe ___	Check conditions you have now or have had in the past: <input type="checkbox"/> HIV+/AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Autoimmune Disorder _____ <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Diabetes I or II <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> High blood pressure: Controlled? Yes No Not Sure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Stroke <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Low libido <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Herpes <input type="checkbox"/> PMS <input type="checkbox"/> Fibroids <input type="checkbox"/> Miscarriages <input type="checkbox"/> Meno/perimenopause symptoms _____ <input type="checkbox"/> Severe allergies _____ Is there anything else you'd like us to know about you? _____ _____ Acupuncturist's notes: _____ _____ _____ _____