BERKELEY ACUPUNCTURE PROJECT

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New Patient Registration and Health Questionnaire

PATIENT INFORMATION

Date of First Visit _____

Name_____

Address_____

City State Zip _____

Age _____ Birthdate _____/_____/_____

Preferred Pronoun ☐She ☐He *Other*_____

Occupation _____

Primary physician_____

CONTACT INFORMATION

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 HISTORY

What are your primary concerns/complaints?

1) _____

Onset:_____ Severity:_____

2) _____

Onset:_____ Severity:_____

3) _____

Onset:_____ Severity:_____

How is your sleep? _____

How would you describe 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:

☐ HIV+/AIDS ☐ Anemia
☐ Arthritis ☐ Asthma
☐ Cancer _____
☐ Autoimmune Disorder _____
☐ Bleeding Disorder ☐ Diabetes I or II
☐ Heart disease ☐ Hepatitis B or C
☐ High blood pressure Controlled? ☐Yes ☐Not Sure
☐ Pacemaker ☐ Stroke

☐ Erection difficulties ☐ Prostate trouble
☐ Low libido ☐ Hemorrhoids
☐ Herpes ☐ PMS
☐ Fibroids ☐ Miscarriages
☐ Meno/perimenopause symptoms _____
☐ Severe allergies _____

Is there anything else you'd like us to know about you?

_____

_____

_____

Acupuncturist's Notes:
T:
P: