Goleta Acupuncture Wellness Clinic
New Patient Registration Form

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you may feel certain questions do not pertain to your present condition. Thank you.

General Information

Name_____ Birth date_____ Today's Date _____

Home Address_____ City_____ State_____ Zip_____

Driver's License No. _____ SSN_____ Patient Status: ☐ Single ☐ Married ☐ Others

Home Phone_____ Cell Phone_____ E-mail _____

If under 18, person responsible for your account: Name _____ Phone _____

Address_____

Emergency Contact: Name_____ Contact Phone:_____ _____

Current Occupation: _____

Employer _____ Work Phone / Email _____

Employer's Adress_____

Are you currently under the medical care of a doctor's care? ☐ Yes ☐ No

If yes, who and for what ?_____

Family Physician if different from above_____ Contact # _____

Are there any other therapies which you are involved in? _____

Whom should we thank for referring you to our office? _____

Have you had Acupuncture or Oriental Medicine before? ☐ Yes ☐ No

Insurance Information

Insurance Company_____ Plan Name _____ Contact #_____

ID #_____ Copay $_____ Visits #_____ Referral ☐ Yes ☐ No Covered % _____

Claim Mailing Address _____

Date Called _____ Contact Name _____

Vitals:

Height _____ft_____in_ Weight _____lbs_ Blood Pressure _____ /_____ mmHg

Heart Rate _____/minutes__ Body Temperature _____^{o}F

Medical History

What is your primary reason for seeking care at our office? _____

_____

When did it first happened? _____

What was the initial cause? _____

What makes it worse?_____

What makes it better?_____

How does this problem interfere with your daily activities:

- ☐ Work
- ☐ Sleep
- ☐ Walk
- ☐ Sitting
- ☐ Standing
- ☐ Exercise
- ☐ Relationships
- ☐ Social life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____

What have you done about this? _____

_____

Please list any surgeries or major health incidents and traumatic injuries in your life _____

_____

Please indicate if any of the following applies to you:

- ☐ Allergies
- ☐ Hepatitis A, B, C
- ☐ Jaundice
- ☐ High / Low Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Obesity
- ☐ Hypo / Hyper Thyroid
- ☐ TB
- ☐ HIV
- ☐ Blood ??
- ☐ Anemia
- ☐ Arthritis
- ☐ Obesity
- ☐ Seizures
- ☐ Epilepsy
- ☐ Arrhythmia (Irregular Heart Beat)
- ☐ Pacemaker
- ☐ Chemo/Radiation
- ☐ Pregnancy
- ☐ Kidney Stone
- ☐ Multiple Sclerosis
- ☐ Gout
- ☐ Cancer
- ☐ Drug Reaction
- ☐ Herbs Reaction
- ☐ Mental Illness
- ☐ Mental Breakdown
- ☐ Parasites
- ☐ Measles /Mumps / Rubella
- ☐ Other Childhood Disease
- ☐ Syphilis
- ☐ Gonorrheal / Herpes
- ☐ Other STDs
- ☐ HIV/AIDS
- ☐ Blood-thinning Meds
- ☐ Hemophilia (blood-coagulation disorders)

Please list any prescription, over-the-counter medications, or nutritional supplements you are presently taking (attach additional page if needed):

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____
7. _____	8. _____	9. _____
10. _____	11. _____	12. _____

Which of these environments affect you adversely?

□ Cold	□ Damp	□ Windy	□ Foggy
□ Heat	□ Dry	□ Humid	

Which of these environments make you feel better?

□ Cold	□ Damp	□ Windy	□ Foggy
□ Heat	□ Dry	□ Humid	

Do you have intolerance to hot or cold (food, drink, or areas of the body that are hot or cold)?

_____

Daily Habits (how much of the following substances do you consume daily?)

Coffee _____ Soda pop _____ Water _____

Alcohol_____ Recreational drugs _____ Tobacco_____

Dairy Products (milk, cheese, yogurt, butter, ice cream, etc.) _____

Meats / fish / Poultry _____

Breads & Grains _____

Cooked vegetables _____

Raw fruit /vegetables _____

Specific food /flavor cravings _____

Daily sugar content _____

Typical Day's Menus:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Are there any foods that you are allergic or sensitive to? _____

Types of Care

Corrective Care	Maintenance Care	Wellness & Preventive Care
Chronic Symptoms and Signs Get me out of pain and discomfort first.	Symptoms and signs disappear Feeling good, no big problems!	You are feeling great! Life is wonderful!
Most patients begin acupuncture treatment o relieve pain, discomfort and other symptoms first. Acute care helps you to ease your initial problems quickly.	Maintenance care gives you a chance to deeper healing to occur. Strengthening your body's immunity to illness by stimulating your natural healing power.	Wellness care is the best choice for people who want to achieve optimal health and well-being, free of disease and illness.

What are your health goals? ☐ Symptom Relief ☐ Deeper Healing ☐ Optimal Health

Signs & Symptoms

Digestive System

- □ Abdominal pain
- □ Acid regurgitation
- □ Vomiting
- □ Belching
- □ Hiccups
- □ Low appetite
- □ Bloody stools
- □ Constipation, dry tool
- □ Heaviness
- □ Hemorrhoids
- □ Thirsty
- □ Indigestion
- □ Nausea
- □ Rib or side pain
- □ Stomach ulcer
- □ Stomach pain
- □ Not thirsty
- □ Undigested food in stool
- □ Weight gain
- □ Poor appetite
- □ Always hungry
- □ Like cold drink
- □ Stomach bloating
- □ Organ prolapse
- □ Burning sensation in anus
- □ Loose stool
- □ Like warm drink

Urogenital

- □ Bladder/ kidney infections
- □ Bloody urine
- □ Cloudy urine
- □ Dark urine
- □ Infertility
- □ Miscarriage
- □ Low libido
- □ Wake to urinate ___x per night
- □ Frequent urination
- □ Incontinence
- □ Nocturnal emission
- □ Impotence
- □ Premature ejaculation
- □ Prostate issues
- □ Vaginal discharge
- □ Water retention
- □ Other (specify)

Head

- □ Blurred vision
- □ Deafness
- □ Dizziness
- □ Ringing in ear
- □ Flushed face
- □ Headache
  - Location
  - Frequency
- □ Poor memory
- □ Poor vision
- □ Tongue or mouth sores
- □ Tooth loss
- □ Tooth abscess
- □ Swollen, bleeding gums
- □ Bad breath
- □ Thirst
- □ Hair loss

Emotions

- □ Anger, frustration
- □ Anxiety
- □ Bi-polar disorder
- □ Depression
- □ Fear
- □ Hysteria
- □ Irritable
- □ Excessive worry
- □ Sadness
- □ Grief

Sleep

- □ Difficulty falling asleep
- □ Dream disturbed sleep
- □ Nightmares
- □ Night sweat
- □ Sleep talk/walk
- □ Difficulty stay in sleep
- □ Wake early at ____am, back to sleep at ____am
- □ Feel hot at night / sleep with windows open
- □ Wake up unrested
- □ Bedtime schedule: ____a/p - ____a/p

Dermatology

- □ Brittle nails
- □ Dry skin
- □ Itchy skin
- □ Rashes
- □ Psoriasis
- □ Acne
- □ Eczema
- □ Other (specify)

Respiratory and Chest

- □ Allergies
- □ Asthma / wheezing
- □ Sensation of object in throat
- □ Coughing
- □ Frequent colds
- □ Hard to project voice
- □ Pneumonia, bronchitis
- □ Radiating chest pain
- □ Shortness of breath
- □ Sighing
- □ Coughing or spitting up mucus
- □ Palpitations
- □ Sore throat

Musculoskeletal

- □ Achy joints
- □ Lower back pain
- □ Sore muscles
- □ Spasms
- □ Weak knees
- □ Swollen painful joints

Circulatory

- □ Always cold
- □ always hot
- □ hot/cold sensation in the body
- □ Cold limbs
- □ Cold hands and feet
- □ Symptom relieved by cold
- □ hot palms and feet
- □ symptoms relieved by heat
- □ Alternating fever and chills
- □ Stroke
- □ Blood clots
- □ bruise easily
- □ masses, lumps, or tumors
- □ numbness
- □ tingling
- □ paralysis
- □ spasms

Others

Energy Level :
- □ Normal
- □ Low /Fatigue
- □ High

Stress Level:
- □ Normal
- □ Low
- □ High

Female Concerns

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow_____

□ Peri-menopause □ Menopause

Color of flow:

□ pale/light red
□ red
□ bright red
□ dark red
□ dark red/brown
□ clots

Amount of flow:

□ spotting
□ light
□ even throughout
□ heavy

# of pads you use per day:

1st day ____
2ND day ____
3RD day ____
4th day ____
+ days ____

Pain and cramping:

□ No
□ Yes
□ before flow □ mild
□ during flow □ moderate
□ after flow □ severe

Other symptoms related to menses:

□ Discharge □ PMS □ Headache □ Nausea
□ Diarrhea □ Swollen breasts □ Mood swings □ Increased appetite
□ Constipation □ Feeling cold □ Insomnia □ Decreased appetite

Have you ever been diagnosed with:

□ fibrocystic breasts □ fibroids □ endometriosis □ ovarian cysts
□ polycystic ovary syndrome □ PID □ STD _____

Male Concerns

History of impotence, premature ejaculation, fertility difficulties, discharge form penis, vasectomy, etc. _____

_____

Others concerns _____

_____

Pain Patients

Please describe the areas of the body you experience your pain: _____

_____

How would you characterize your pain: □ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

Any additional information_____

_____

_____

_____

PAIN PATIENTS , You can also indicate on the figures below the areas of the body you experience your pain: