BENEVOLENT ACUPUNCTURE & WELLNESS CENTER

NEW PATIENT REGISTRATION FORM

Today's Date: _____ Patient ID: _____

BASIC INFORMATION					
Patient's last name:			First Name:		Middle:
Date of Birth:	Gender: ☐ M ☐ F	Marital status: ☐ Single ☐ Married ☐ Divorced	Occupation:		Employer:
Who may we thank for referring you?	☐ Person	☐ Doctor	☐ Insurance	☐ Internet	☐ Others

CONTACT INFORMATION	
Address:	
Primary Phone Number:	Email Address:
Emergency Contact Name, Phone, & Relationship:	

INSURANCE INFORMATION			
Insurance Company:	☐ Aetna ☐ Horizon BCBS ☐ Cigna ☐ United Healthcare ☐ Other _____		
Relationship to Insured:	☐ Self ☐ Spouse ☐ Child	Member ID:	
Name of Insured:	Date of Birth of Insured:	Phone Number of Insured:	
Address of Insured:			
Primary Physician **Name** and **Phone Number**:			

HEALTH INFORMATION

Your main reason of the visit? _____

_____

Do you have any metallic implants, pacemakers, metallic sutures, etcs? ☐ N ☐ Y ➔ Where? _____

Please check if you have/had any: (O=Previously, ☐ = Now)

General				
O ☐ Anemia	O ☐ Fatique	O ☐ Poor Appetite	O ☐ Tremors	O ☐ Localized Weakness
O ☐ Fever	O ☐ Weight Loss	O ☐ Weight Gain	O ☐ Chills	O ☐ Drug Addiction
O ☐ Bleed or Bruise Easily	O ☐ Peculiar Tastes or Smells	O ☐ Strong Thirst (hot or cold drinks)	O ☐ Sudden Energy drop	O ☐ Poor Sleep Habits
O ☐ Poor Balance	O ☐ Cravings	O ☐ Sweats	O ☐ Alcoholism	O ☐ Tetanus Shot
O ☐ Frequent Cold/Flu				

Skin and Hair				
O ☐ Rashes	O ☐ Itching	O ☐ Dandruff	O ☐ Open Sore	O ☐ Recent modes
O ☐ Hives	O ☐ Acne	O ☐ Corns	☐ Warts	☐ Psoriasis
O ☐ Dry skin	O ☐ Eczema	O ☐ Change in hair/skin texture	O ☐ Ulcerations	

Head, Eyes, Ears, Nose, and Throat				
O ☐ Dizziness / Vertigo	O ☐ Headache	O ☐ Migraines	O ☐ Concussions	O ☐ Poor Vision
O ☐ Eye Strain	O ☐ Eye Pain	O ☐ Night blindness	O ☐ Color Blindness	O ☐ Blurry Vision
O ☐ Earaches	O ☐ floaters in eyes	O ☐ Cataracts	O ☐ Ringing Ears	O ☐ Poor Hearing

O ☐ Nose Bleeds	O ☐ Nasal Congestion	O ☐ Sinus Problems	O ☐ Recurrent Sore Throat	O ☐ Hoarseness
O ☐ Grinding Teeth	O ☐ Facial pain	O ☐ Facial numbness	O ☐ Facial muscle twitching	O ☐ Bell's Palse
Cardiovascular				
O ☐ High Blood Pressure	O ☐ Low Blood Pressure	O ☐ Palpitations	O ☐ Irregular Heartbeat	O ☐ Mitral Stenosis
O ☐ Mitral Prolapse	O ☐ Myocarditis	O ☐ Pneumatic Heart Disease	O ☐ Chest Pain	O ☐ Varicose Veins
O ☐ Swelling of Hands/ Feet	O ☐ Fainting	O ☐ Coronary Heart Disease	O ☐ Difficulty in Breathing	O ☐ Hardening of Arteries
O ☐ Phlebitis	O ☐ Blood Clots	O ☐ Cold Hands/ feet		
Respiratory				
O ☐ Cough	O ☐ Bronchitis	O ☐ Difficult breathing when lying down	O ☐ Emphysema	O ☐ Coughing Blood
O ☐ Pneumonia	O ☐ Asthma	O ☐ Pain w/ deep breath	O ☐ Production of phlegm	O ☐ Pleurisy
Gastrointestinal				
O ☐ Nausea	O ☐ Vomiting	O ☐ Bad Breath	O ☐ Abdominal Pain or Cramps	O ☐ Indigestion
O ☐ Ulcer	O ☐ Constipation	O ☐ Gas	O ☐ Blood in stools	O ☐ Rectal Pain
O ☐ Chronic Laxative use	O ☐ Colitis	O ☐ Diarrhea	O ☐ Belching	O ☐ Black Stools
O ☐ Hemorrhoids	O ☐ Acid Relux			
Genitourinary				
O ☐ Bed Wetting	O ☐ Blood in Urine	O ☐ Frequent Urination	O ☐ Kidney Infections/Stones	O ☐ Painful Urination
O ☐ Bladder Infections	O ☐ Genital Herpes	O ☐ Venereal Disease	O ☐ Prostate Problems	O ☐ Cystitis
O ☐ Incontinence				
Pregnancy and Gynecology				
___ # of pregnancies	____ age at 1st menstruation	____# of mis-carriages	O ☐ Irregular Heartbeat	O ☐ Mitral Stenosis

Are you on any medication? _____

_____

_____

PATIENT'S SOCIAL HISTORY & LIFESTYLE

It is important that we understand your general lifestyle as it often has a significant impact on your overall health. Please check mark the box which most closely describes your general lifestyle for each question.

	None	Light	Moderate	Heavy	
Smoking	☐	☐ <= ¼ pack / day	☐ ½ pack/day	☐ ¾ pack/ day	☐ 1 pack/day
Alcohol	☐	☐ <= 1 drink/week	☐ 2-7 drinks/week	☐8 -14 drinks/week	☐ >= 15-21 drinks/wk
Caffeine	☐	☐ 1 cup/ day	☐ 2 cups/ day	☐ 3 cups/day	☐ > 4 cups / day
Exercise	☐	☐ 1 day /week	☐ 2 days / week	☐ 3 days/week	☐ > 3days / week
Diet (Vegetables/Fruits)	☐	☐ < 3 servings / week	☐ 2-4 servings/week	☐ > 4 servings/week	
Sleep (# of hours/day)		☐ <= 6 hours	☐ 7- 8 hours	☐ > 8 hours	
Stress (10=highStress)	☐ Steady ☐UP & Down		☐ 1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10		