

Ann Arbor Healing Arts, LLC

NEW PATIENT REGISTRATION FORM

This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you.
If you have questions/concerns regarding any of the following, please ask. Thank you.

Full Name _____ Name preference _____ Date _____
Home Address _____
City _____ State _____ Zip _____ Email Address _____
Home Phone (____) _____ Work (____) _____ Cell (____) _____
Best # to call (____) _____ OK to leave message? Y N Best time to call ____AM ____PM
Emergency contact: _____ Relationship: _____ Phone: (____) _____

Ann Arbor Healing Arts, LLC will never sell or transfer your information to third parties.
May we send you updates & information? Y N
May we contact you by email? Y N by regular post? Y N

Age _____ Date of birth _____ Gender: F M Height _____ Weight _____
 Married Partnered Single Divorced Widowed # Number of children _____
Occupation _____ Employer _____
Whom may we thank for referring you? _____

What is the reason for today's visit? _____

If "pain" is this due to: Auto accident Injury/Trauma Work-related Other: _____
_____ Date of accident/injury/onset _____

How long have you had this? _____ Have you had this before? Y N
If yes, when? For how long? _____

Have you sought other treatment/consulted another medical professional for this? Y N
If yes, what and when? _____ Was this helpful? Y N

Doctor's Name _____ Phone _____
Address _____
Date of last physical _____

Please list any other health problems/concerns you have: _____

What are your health goals? _____
Short term goals (1-4 weeks) _____
Long term goals (1-12 months) _____

FAMILY MEDICAL HISTORY: Are you adopted? Y N

Please check "✓" all that apply & indicate you and/or a blood relative (grandparent, parent, sibling).

	You	Relative-who?	Date		You	Relative-who?	Date
Alzheimer's	___	_____	___	Arthritis	___	_____	___
Cancer	___	_____	___	Diabetes	___	_____	___
Emotional disorders	___	_____	___	Gallbladder disease	___	_____	___
Heart disease	___	_____	___	Hepatitis	___	_____	___
High blood pressure	___	_____	___	Infectious disease	___	_____	___
Neurological disorder	___	_____	___	Rheumatic Fever	___	_____	___
Seizures	___	_____	___	Stroke	___	_____	___
Thyroid disorder	___	_____	___	Tuberculosis	___	_____	___
Other: _____	___	_____	___	Other: _____	___	_____	___

DIAGNOSTIC TESTING: Please check "✓" all that apply.

___ Blood work	When? _____	Results: _____
___ CT scan	When? _____	Results: _____
___ EKG	When? _____	Results: _____
___ MRI	When? _____	Results: _____
___ Urinalysis	When? _____	Results: _____
___ X-Ray	When? _____	Results: _____
___ Other: _____	When? _____	Results: _____

HOSPITALIZATIONS:

If you have been hospitalized for any serious medical illness, injury, or surgery, please write in your most recent hospitalization(s) below. Check "✓" this box if you had more than three such hospitalizations. (Do not include normal pregnancies).

Most recent hospitalization:	_____	_____	_____
	Year	Operation/Illness	Hospital/City/State
Previous hospitalization:	_____	_____	_____
	Year	Operation/Illness	Hospital/City/State
Previous hospitalization:	_____	_____	_____
	Year	Operation/Illness	Hospital/City/State

MEDICATIONS/SUPPLEMENTS: Please check "✓" the box next to all you are currently taking.

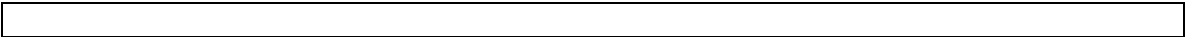
<input type="checkbox"/> Advil/Ibuprofen/Tylenol	<input type="checkbox"/> Cold medication	<input type="checkbox"/> Hormone Replacement
<input type="checkbox"/> Allergy medication	<input type="checkbox"/> Oral contraceptive medication	<input type="checkbox"/> Interferon
<input type="checkbox"/> Antacids	<input type="checkbox"/> Coumadin/Warfarin	<input type="checkbox"/> Laxatives
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> DHEA/Melatonin	<input type="checkbox"/> Steroids
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Diet pills	<input type="checkbox"/> Supplements: vitamin/mineral
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Diuretics	<input type="checkbox"/> Tranquilizers/sleeping pills
<input type="checkbox"/> Blood pressure medication	<input type="checkbox"/> Herbal formulas/tinctures	<input type="checkbox"/> Viagra

Please list the names of all medications/supplements you are currently taking (continue on back, if needed):

Medicine/Dosage	Reason	How Long	Prescribed by	Last checkup
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LIFESTYLE HABITS: Please check "✓" the box next to all that apply.

Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, # drinks/week _____	Age started _____
Artificial sweetener	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how much? _____	
Caffeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	# coffees/day _____ # sodas/day _____ # teas/day _____	
Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never	
Recreational Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never	
Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, # cigarettes/cigars/day _____	Age started _____
Water Intake	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how much? _____	



SYMPTOM SURVEY: Following is a list of symptoms you may or may not ever experience. Please check “✓” as follows:

Never experience: _____ (leave blank)
 Sometimes experience: “✓”
 Frequently experience: “✓✓”

___ cough ___ nasal problems ___ bronchitis ___ hemorrhoids ___ coughing blood	___ shortness of breath ___ feelings of claustrophobia ___ colitis or diverticulitis ___ recent antibiotic use ___ production of phlegm: Color: _____	___ decreased sense of smell ___ sinus congestion ___ constipation ___ skin problems Please detail: _____
___ insomnia/difficulty sleeping ___ nightmares ___ angina pain ___ mentally restless	___ laughing for no apparent reason ___ heart palpitations ___ abdominal pain ___ pain or coldness in genitals	___ cold hands and feet ___ chest pain ___ sciatic pain ___ headache/where? _____
___ lack of appetite ___ digestive problems ___ tendency to obsess: work, relationships, etc	___ excessive appetite ___ vomiting ___ feeling of retention of food in the stomach	___ loose stools or diarrhea ___ belching, burping ___ heartburn/reflux ___ bloating, gas
___ jaundice ___ light colored stools ___ difficulty making decisions ___ eye problems/floaters	___ difficulty digesting oily foods ___ soft or brittle nails ___ easily angered/agitated ___ muscle spasms/twitching	___ gallstones ___ eye twitching ___ tendency to faint ___ fibrocystic breasts
___ low back pain ___ ear ringing ___ hair loss ___ edema ___ easily bruised ___ allergies ___ tendency to catch colds ___ nighttime urination # _____	___ knee problems ___ kidney stones ___ urinary problems ___ blood in stool ___ difficulty stopping bleeding ___ hay fever ___ intolerance to changes in weather/season	___ impaired hearing ___ decreased sex drive ___ urinary infection ___ black tarry stools ___ asthma ___ dizziness ___ head injury date: _____
Sexually transmitted infections: ___Gonorrhea ___Syphilis ___HIV ___Chlamydia ___Herpes Related medications: _____		
CRAVINGS: ___ Salty ___ Sour ___ Sweet ___ Fatty/Greasy ___ Snacks btwn meals		
DIET: ___ Macrobiotic ___ Raw food ___ Vegan ___ Vegetarian ___ Other: _____		
SKIN: ___ Acne ___ Dandruff ___ Eczema ___ Itching ___ Psoriasis ___ Rashes		
SWEAT: ___ Easily ___ Rarely ___ Hot flashes ___ Night sweats ___ Palms/Feet ___ All-over		
TEMPERATURE: ___ Feel cold: Where? _____ ___ Feel hot: Where? _____ ___ Fever/chills		

MENTAL / EMOTIONAL SELF-REPORT: Please circle the number that describes you.

How do you feel about:	Fair → Great	Fair → Great	Fair → Great
Your Life	1 2 3 4 5	Your Creativity	1 2 3 4 5
Your Health	1 2 3 4 5	Your Physical Activity	1 2 3 4 5
Your Family	1 2 3 4 5	Your Spirituality	1 2 3 4 5
Your Relationships	1 2 3 4 5	Your Profession	1 2 3 4 5

WOMEN:

Age at first menstrual period: ____ Age at menopause: ____ Number of days between periods: _____

Number of days of flow: _____ Color of flow: _____ Clots? Y N Color: _____

Number of pads/tampons you use per day: Day 1 ____ Day 2 ____ Day 3 ____ Day 4 ____ Day 5 ____

Have you been diagnosed with: Cysts Fibrocystic breasts Fibroids Endometriosis PCOS

Other symptoms related to menstruation: _____

Please check box next to all that apply. Circle before "B," during "D," or after "A" menses:

PAIN: Aching B D A Burning B D A Cramping B D A
 Dull B D A Sharp B D A Stabbing B D A
 Intermittent B D A Constant B D A "Bearing down" sensation B D A

Vaginal dryness B D A Discharge ____/Color ____/Odor ____
 Constipation B D A Diarrhea B D A Headache B D A
 Swollen breasts B D A Bloating B D A Nausea B D A
 Night sweats B D A Insomnia B D A Hot Flashes B D A
 Mood swings B D A Low appetite B D A Big appetite B D A
 Increased libido B D A Low libido B D A Cravings B D A

Pregnancy History: Are you pregnant? Y N If "yes," what is your due date? _____
 # pregnancies _____ # live births _____
 # abortions _____ # miscarriages _____

Do you want to become pregnant? Y N Are you currently trying to get pregnant? Y N

Date/results of most recent:
 Gynecological exam: _____ PAP smear: _____
 Bone density scan: _____ Mammogram: _____

MEN:

Date of most recent prostate check-up: _____ PSA results: _____

Manual prostate exam and lab results: _____

Frequency of Urination: Daytime: # _____ Nighttime: # _____

Color of Urine: Clear Cloudy Yellow Dark Strong odor

Please check box next to all that apply:

Back pain Testicular pain Groin Pain Painful urination
 Dribbling Incontinence Delayed stream Retention of Urine
 Impotence Decreased libido Increased libido Premature ejaculation
 BPH/prostate Weak erections (ED) Rectal dysfunction Decreased force of stream

Are you and your spouse/partner currently trying to get pregnant? Y N

If you have been unable to conceive, have you had medical testing for this issue? Y N

If yes, what were the results: _____

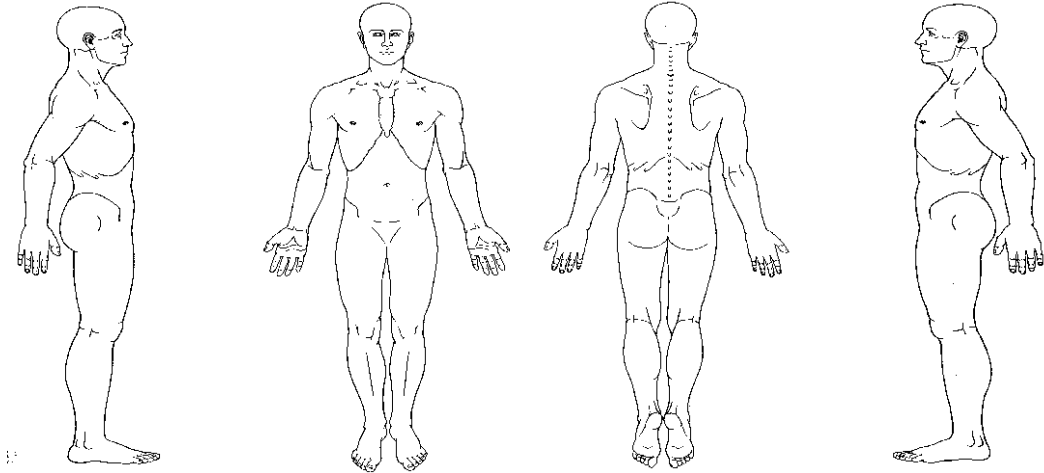
PAIN:

Are you experiencing acute or chronic pain? Y N Since when? _____ Please describe: _____

What activities cause this pain or make it worse: _____

What makes it better: _____

Shade in your pain pattern below – use heavier shading in areas of more intense pain:



Patient's Right side

Patient's Left side

ALL PATIENTS: Please check box for any of the following that are true:

I have known allergies. If so, please list any allergies (medications, etc) or food sensitivities you have: _____

I'm taking a blood thinner (Coumadin/Warfarin). I have a Pacemaker. I'm taking Lithium.

Have you received acupuncture before? Y N If so, when? _____

With whom? _____

Are there any issues of emotional/physical/sexual trauma or abuse you would like to discuss? Y N

Are there any other issues or concerns you'd like to discuss? Y N

The above information is accurate and true to the best of my knowledge. I understand that an acupuncture appointment could include acupuncture, cupping, guasha, moxabustion, dietary or nutritional counseling, flower essences, herbal formulas, homeopathic remedies, Qigong or other breathing exercises, stretching, therapeutic massage, and bodywork. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I understand that I am responsible for full payment for any and all scheduled appointments, including missed appointments and appointments cancelled without 24 hours notice (excepting emergency situations). Payment is due at time of service. **Ann Arbor Healing Arts, LLC** abides by HIPAA guidelines and respects the privacy of all patients. I have been provided a copy of the **Ann Arbor Healing Arts, LLC ~ Notice of Privacy Practices**. If I have questions or concerns before, during, or after treatment, I will bring them to the attention of my practitioner.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____