



New Patient Registration

This is a CONFIDENTIAL questionnaire. Your current and past health history will be evaluated in order to provide a customized treatment plan that meets your medical and wellness goals.

Full Name _____ Name Preference _____

Home Address _____ City _____

State _____ Zip _____ Email _____

Home (____) _____ Work (____) _____ Cell (____) _____

Please mark above which number(s) you will prefer to receive messages. Best time to call _____ AM _____ PM

Date of Birth _____ Age _____ Adopted Y N Sex: Female Male Trans FTM MTF

Marital Status: Married Partnered Single Divorced Widowed Number of Children _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____

Phone 1. (____) _____ Phone 2 (____) _____

Who may we thank for referring you? _____

Healthy Happy Whole will never sell or transfer your information to third parties.
May we contact you for follow up care and to share important clinic updates: Yes No
Appointment reminder preference: Email Text

Height _____' _____" Weight _____ 1 year ago _____ lbs. Adult Max _____ lbs. Adult Minimum _____ lbs.

Known Allergies _____

Blood Type: A O B AB Unknown Do you regularly donate blood? Yes No

Rh Factor: Positive Negative Unknown Have you ever had a blood or plasma transfusion? Yes No

Date of last physical exam _____ With whom _____

Reported findings _____

Surgeries, Hospitalizations, Serious Illnesses (List year in brackets) _____

Fractures, Dislocations, Major Dental Work (List year in brackets) _____

Purpose of this Appointment _____

Have you sought other treatment / consulted another medical professional for this condition? Yes No

If yes, what forms of treatment have you sought? _____ When _____

Were the treatments helpful? Yes No Explain _____

Doctor's Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Email _____ You have my permission to contact my doctor

Please list any other health concerns _____

What are your overall wellness goals? _____

Please mark the following boxes with an **X** = Current Use **✓** = Previous Use

LIFESTYLE HABITS

Caffeine # Coffee/day _____ # Sodas/day _____ Diet Regular # Tea/day _____
 Alcohol # Drinks/week _____ Type _____ Started at Age ___ Quit ___
 Tobacco # Cigarettes/day _____ Brand _____ Started at Age ___ Quit ___
 Recreational Drugs: Daily Weekly Monthly Rarely

DIET

Food cravings _____ Salty Sweet Sour Bitter Fats/Greasy
 Known food sensitivities _____

Mark any dietary choices that apply: Vegetarian Vegan Macrobiotic Raw Other _____

Do you eat at restaurants? Yes No # of Times per week? _____ Where _____

Are you currently Dieting? Yes No If yes, please describe _____

OTHER

Do you sleep well? Yes No Sleep _____pm/am Wake _____pm/am Average Hours/night _____

If no, please describe _____

Do you have enough energy for normal activities? Yes No _____

Has your vision changed recently? Yes No _____

Bowel Frequency _____ # Times/day Difficulty Yes No _____

Urinary Frequency _____ # Times/day Difficulty Yes No Do you wake to urinate? Yes No ___#/night

Do you wear heel lifts or foot supports? Yes No

SYMPTOM SURVEY

Please mark the list of symptoms you: **+** Frequently experience
✓ Sometimes experience

<input type="checkbox"/> Lack of appetite	<input type="checkbox"/> Digestive problems, indigestion	<input type="checkbox"/> Heartburn, reflux
<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Vomiting / Nausea	<input type="checkbox"/> Belching, burping
<input type="checkbox"/> Loose stool or diarrhea	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Abdominal bloating
<input type="checkbox"/> Constant worry	<input type="checkbox"/> Feeling retention of food in the stomach	<input type="checkbox"/> Irritability eased with food
<input type="checkbox"/> Mind racing	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Easily bruised
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Tension headache
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Sciatic pain	<input type="checkbox"/> Migraine
<input type="checkbox"/> Mentally restless	<input type="checkbox"/> Pain or coldness in the genital area	<input type="checkbox"/> Laughing for no reason
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Abdominal pain	
<input type="checkbox"/> Cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Sinus Congestion
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Allergies
<input type="checkbox"/> Decreased sense of smell	<input type="checkbox"/> Recent use of antibiotics	<input type="checkbox"/> Constipation
<input type="checkbox"/> Nasal problems	<input type="checkbox"/> Phlegm: <input type="checkbox"/> Nose <input type="checkbox"/> Chest/cough	<input type="checkbox"/> Colitis or diverticulitis
<input type="checkbox"/> Skin problems	Easy to expectorate: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Unexplained weight loss	Color: <input type="checkbox"/> Clear <input type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Brown <input type="checkbox"/> Green	
<input type="checkbox"/> Muscle spasms/twitching	<input type="checkbox"/> Easily angered or agitated	<input type="checkbox"/> Difficulty digesting oily foods
<input type="checkbox"/> Eye twitching	<input type="checkbox"/> Difficulty making plans or decisions	<input type="checkbox"/> Jaundice (yellowish skin or eyes)
<input type="checkbox"/> Eye problems/floaters	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gallstones
<input type="checkbox"/> Soft, brittle nails	<input type="checkbox"/> Intestinal gas	<input type="checkbox"/> Light colored stool
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Often cold, prefers warmth	<input type="checkbox"/> Urinary problems
<input type="checkbox"/> Knee problems	<input type="checkbox"/> Intolerance to weather changes	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Tendency to catch colds easily	<input type="checkbox"/> Black tarry stool
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Edema
<input type="checkbox"/> Decreased sex drive		
<input type="checkbox"/> Acne	<input type="checkbox"/> Rashes	<input type="checkbox"/> Sweating: <input type="checkbox"/> Easily <input type="checkbox"/> Rarely <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats
<input type="checkbox"/> Eczema	<input type="checkbox"/> Itching	<input type="checkbox"/> Temperature: <input type="checkbox"/> Cold <input type="checkbox"/> Warm <input type="checkbox"/> Over-heated
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Dandruff	<input type="checkbox"/> STD: <input type="checkbox"/> HIV <input type="checkbox"/> Herpes <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Clamydia <input type="checkbox"/> HPV

How do you feel about your:

MENTAL / EMOTIONAL SELF REPORT

	Fair	→	Great		Fair	→	Great		Fair	→	Great	
Life	1	2	3	4	5	Partner / Spouse	1	2	3	4	5	NA
Health	1	2	3	4	5	Profession	1	2	3	4	5	NA
Family	1	2	3	4	5	Creativity	1	2	3	4	5	
Relationships	1	2	3	4	5	Emotional support	1	2	3	4	5	
						Exercise	1	2	3	4	5	
						Diet	1	2	3	4	5	
						Spirituality	1	2	3	4	5	
						Self	1	2	3	4	5	

OB/GYN HISTORY

Age at first menstrual cycle _____ Are you pregnant? Yes No Uncertain

Age at menopause _____ # Pregnancies _____ # Live births _____

Number of days between periods _____ # Abortions _____ # Miscarriages _____

Number of days of flow _____ Date of last: Gynecologic exam _____

Date of last menstrual cycle _____ Pap smear _____ Mammogram _____

Color of flow: Pale Pink Light red Red Deep red Purple Brown

Regularity: Regular Irregular Early Late Varies

Menstrual flow: Even Uneven Heavy Light

Consistency: Thin Thick Clotted

Please circle the following symptoms according to: B = before D= during A= after

Irritability B D A Breast Tenderness B D A Lower Back Soreness B D A

Bloating B D A Mood Swings B D A Other _____

Cramping B D A Food Cravings B D A _____

Vaginal Discharge Yes No Color/Consistency/Amount _____

Libido/Function: _____

UROGENITAL HISTORY

Date of last prostate exam _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of urination: Daytime _____ nighttime _____ Color of urine: Clear Murky Odor: _____

Please mark the following symptoms. + Frequently experience ✓ Sometimes experience

Prostate problems Delayed stream Post void dribbling Incontinence

Erectile dysfunction Increased libido Decreased libido Premature ejaculation

Back pain Groin pain Testicular pain Decreased force of stream

Urine retention Impotence Rectal dysfunction Enlarged testicals

DIAGNOSTIC TESTING

Blood work Date _____ Results _____ MRI Date _____ Results _____

CT scan Date _____ Results _____ Urinalysis Date _____ Results _____

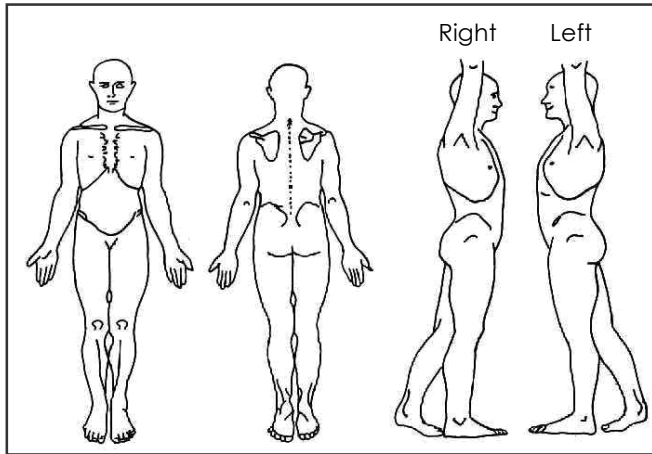
EKG Date _____ Results _____ X-Ray Date _____ Results _____

FAMILY MEDICAL HISTORY

	You	Relative	Year		You	Relative	Year
High blood pressure	_____	_____	_____	Arthritis	_____	_____	_____
Heart disease	_____	_____	_____	Diabetes	_____	_____	_____
Emotional disorder	_____	_____	_____	Gallstones	_____	_____	_____
Eating disorder	_____	_____	_____	Hepatitis	_____	_____	_____
Neurologic disorder	_____	_____	_____	Alcoholism	_____	_____	_____
Seizures	_____	_____	_____	Infectious disease	_____	_____	_____
Alzheimers	_____	_____	_____	Rheumatic fever	_____	_____	_____
Thyroid disorder	_____	_____	_____	Tuberculosis	_____	_____	_____
Anemia	_____	_____	_____	HIV/AIDS	_____	_____	_____
Stroke	_____	_____	_____	Cancer	_____	_____	_____

Do you have chronic, on-going pain? Yes No

Please draw the location of your pain below. Use heavier shading in areas of more intense pain.



Initial onset (Date/Year) _____

Due to: Injury/trauma Auto accident Work-related
 Repetitive stress Other _____

Characteristics: Dull/Achy Sharp/Stabbing Tingling
 Pain moves Localized Comes & goes Constant

What activities cause/make the pain worse? _____

What makes it better? _____

MEDICATIONS

Please mark and list ALL of the medications 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	<input type="checkbox"/> Interferon
<input type="checkbox"/> Antacids	<input type="checkbox"/> Blood thinner (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
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Diuretics	<input type="checkbox"/> Sleeping pills/tranquilizers
<input type="checkbox"/> Blood pressure medication	<input type="checkbox"/> Herbal formulas/tinctures	<input type="checkbox"/> Viagra/Cialis

List the names of ALL medications/supplements you are currently taking (continue on the back if necessary):

Medicine/Dosage	Reason	How Long	Prescribed by	Last appointment

PATIENT PROFILE

Have you received acupuncture/dry needling before? Yes No If so, when? _____

With whom? _____

Licensed Acupuncturist/DAOM Doctor / Chiropractor Other _____

MEDICAL REMINDER

I have a Pacemaker I have Allergies to _____ I am Pregnant; I am in Trimester 1 2 3
 I have Hemophilia I am taking a Blood Thinner (Coumadin/Warfarin) I am taking Anti-seizure Medication

PATIENT CONSENT

The above information is accurate and true to the best of my knowledge. I understand that an office visit may include a variety of therapeutic modalities such as physiotherapy, acupuncture therapies, manual therapy, medical massage, dietary and nutritional counseling, herbal therapy, cold and/or heat therapy, Qi Gong, or other therapeutic exercise.

I understand that I am responsible for full payment for any and all scheduled appointments, including missed and cancelled appointments without 24 hours notice. I have read and agree to all terms of the cancellation policy.

I take responsibility for alerting my practitioner to any physical or emotional changes that occur with my health. If I have any questions or concerns before, during or after any treatment, I will bring them to the attention of the practitioner.

Patient Signature _____ Printed Name _____ Date _____

Practitioner Signature _____ Printed Name _____ Date _____