

Patient Registration and Health History

Patient Information

Patient Name: _____
Last Name First Name MI
Date of Birth: ____/____/____ Sex: M F SSN: _____
Weight: _____ lbs Height: _____ ft _____ inches Marital Status: Single Married Other
Work Status: Employed Student Other Professional Title: _____
Address: _____
City State Zip Code
Home: (____) _____ Work: (____) _____ Mobile: (____) _____
Preferred Phone: Home Work Mobile Email: _____

EMPLOYMENT INFORMATION:

Employer Name: _____ Employer Phone: (____) _____
Employer Address: _____
City State Zip Code

EMERGENCY CONTACT:

Contact Name: _____ Relationship to Patient: _____
Home: (____) _____ Mobile: (____) _____

Whom may we thank for referring you? _____

Would you like to receive our email newsletter? Y N Best method to send appointment reminders:
 Text Message E-Mail Phone Don't Need Reminder

ACCIDENT INFORMATION:

Is condition due to an accident? Y N Date: _____ Type of accident: Auto Work Home Other _____
To whom have you made a report of your accident? Auto Insurance Employer Worker Comp Other _____

HEALTH INSURANCE INFORMATION:

Insurance Co: _____ Group #: _____ ID#: _____
Who is responsible for this account? Self Other If other, name of person responsible: _____
Is patient covered by additional insurance? Y N
Insurance Co: _____ Group #: _____ ID#: _____

Assignment and Release Statement

I certify that if I, and/or my dependent(s), have insurance coverage, I shall assign to Radix Acupuncture & Chiropractic and/or its affiliates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also understand that sending in my insurance claim is a courtesy and not a requirement. Radix Acupuncture & Chiropractic and its affiliates/agents may use my health care information and may disclose such information to the health care insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient Condition

Please identify the health concerns that have brought you here in order of importance below:

<u>Condition(s)</u>	<u>Past Treatment</u>
_____	_____
_____	_____
_____	_____
_____	_____

Date of last Physical Exam: _____

General Health: Excellent Good Fair Poor

Which of the following are you interested in hearing more about (check all that applies):

- Acupuncture
 Acupressure, Tui-Na
 Herbal Medicine
 Cosmetic Acupuncture
 Weight Loss
 Chiropractic
 Physiotherapy/Rehab
 Kinesiotaping
 Nutritional Analysis

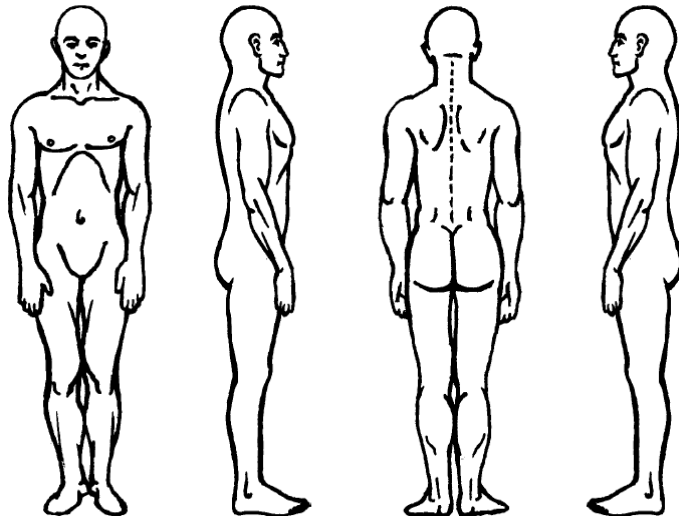
When did your symptom(s) appear? _____

Is the condition getting: better worse stayed the same don't know

Has this occurred before? Yes No If yes, when? _____

Sensations Types (Please mark appropriate symbols on the diagrams)

<u>Symbol</u>	<u>Sensation</u>
XXX	Sharp, Stabbing, Burning
>>>	Shooting, Radiating
NNN	Numbness, Tingling
OOO	Edema, Swelling
AAA	Dull/Achy
TTT	Throbbing
	Other _____



What percentage of the time do you experience this problem? <25% 25% 50% 75% 100%

What relieves the pain? (heat, cold, massage, rest, exercise, other) _____

What makes the pain worse? (weather, heat, cold, movement, other) _____

Activities or movements that are painful to perform: lying down sitting standing walking bending other

Rate your complaint today on a scale of 0 to 10 (0=no pain; 10=worst pain): _____

Does it interfere with your: work sleep daily routine recreation Other _____

Health History

ALLERGIES - Please list any foods, drugs, or medications you are hypersensitive or allergic to (include reaction):

MEDICATION- Please list any medications, vitamins, and supplements you are currently taking:

FAMILY HISTORY - Does your family have any conditions like cancer, diabetes, heart diseases, high blood pressure or cholesterol, stroke, mental illness, asthma, arthritis, kidney or liver disorders, or any other conditions that effect them?

Family member

Present or past health conditions

Mother	_____
Father	_____
Siblings	_____
Grandparents	_____

Explain if you have (or had) any of the following:

AID/HIV _____	Glaucoma _____	Osteoporosis _____
Allergy shots _____	Goiter _____	Pacemaker _____
Anemia _____	Gout _____	Parkinson's disease _____
Appendicitis _____	Heart disease _____	Pinched nerve _____
Arthritis _____	Hepatitis _____	Prostate problems _____
Asthma _____	Hernia _____	Prosthesis _____
Bleeding disorders _____	Herniated disc _____	Rheumatoid arthritis _____
Breast lump _____	High cholesterol _____	Stroke _____
Bronchitis _____	Infertility _____	Sexual dysfunction _____
Cancer _____	Kidney disease _____	Thyroid problems _____
Chemical dependency _____	Liver disease _____	Tuberculosis _____
Diabetes _____	Menstrual problems _____	Tumors, Growths _____
Emphysema _____	Mental disorders _____	Ulcers _____
Epilepsy _____	Migraine/Headaches _____	Vaginal infections _____
Fractures _____	Miscarriage _____	Others _____

Do you have any infectious diseases? Yes No If yes, please identify: _____

PREVIOUS INJURIES, SURGERIES, HOPITALIZATIONS – Please describe below (if any):

	Description	Date
Accidents/Falls	_____	_____
Head Injuries	_____	_____
Fractures	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Hospitalizations	_____	_____

LIFESTYLE

How many meals per day do you eat? _____ Do you snack often? Yes No
 How many hours per night do you sleep? _____ Do you wake rested? Yes No

Exercise (explain)

None _____

Moderate _____

Daily _____

Heavy _____

Work Activity (explain)

Sitting _____

Standing _____

Light Labor _____

Heavy Labor _____

Habits (explain)

Smoking _____ Packs/day _____

Alcohol _____ Drinks/week _____

Soft drinks _____ Cans/day _____

Coffee _____ Cups/day _____

Tea _____ Cups/day _____

Water _____ Cups/day _____

Stress level _____ Rate(0-10) _____

Symptoms

GENERAL

	severe	mild	none
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills/Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shooting pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unclear thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others _____			

GASTROINTESTINAL

	severe	mild	none
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen distention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worms/Parasites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others _____			

RESPIRATORY

	severe	mild	none
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing/Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SKIN

	severe	mild	none
Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruises easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others _____			

MUSCLES & JOINTS

	severe	mild	none
Back pain/Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow/Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee/Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others _____			

E.E.N.T.

	severe	mild	none
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Far sightedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near sightedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gum trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others _____			

GENITOURINARY

	severe	mild	none
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't control urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infection/stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pus in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others _____			

CARDIOVASCULAR

	severe	mild	none
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others _____			

MEN ONLY

Burning with urination	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Difficulty starting urine	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Dribbling after urination	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Prostate trouble	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Get up at night to urinate	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
How many times/night: _____				
Feeling incomplete bowel evacuation	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Others _____				

WOMEN ONLY (Are you pregnant? No Yes Due Date: _____)

Irregular periods	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	Headaches with period	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	Premenstrual depression	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Hot flashes	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	Menstrual cramps	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	Painful breasts	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Vaginal discharge	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	Excessive flow	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	Lumps in breasts	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Hysterectomy	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	Menopausal symptoms	<input type="checkbox"/>	Y	<input type="checkbox"/>	N					

Last menstrual date: _____ Amount of days: _____ Amount of flow: Scanty Moderate Heavy
 Sticky? Y N Clots? Y N Pain? Y N Color of menses: Pink/Light Red Bright Red Brown/Dark Red

Please use the following lines to further explain any of the above conditions: _____

Informed Consent Statement

I hereby authorize the staff of Radix Acupuncture & Chiropractic and its affiliates to conduct examinations, chiropractic adjustments, acupuncture treatments and other procedures necessary, including but not limited to various modalities of physiotherapy, soft-tissue techniques, cupping, tui-na, and electro-acupuncture on me or on the patient for whom I am legally responsible.

I understand that, as in the practice of medicine, in the practice of chiropractic, and in the practice of acupuncture, there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the staff of Radix Acupuncture & Chiropractic and its affiliates to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner and/or his staff to exercise judgment during the course of the procedures which he feels at the time, based on the fact then known, are in my best interests. I have had an opportunity to discuss with the doctor of chiropractic and/or acupuncturist and/or with other office or clinic personnel the nature and purpose of chiropractic and acupuncture related procedures. I understand that results are not guaranteed.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat/smoke to the skin (or both) at certain points near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result.

These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping/Tui-Na Massage: I understand that I may also be given cupping/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensing physician.

I have read, or have had read to me, the above consent. I agree to the above, and allow the staff of Radix Acupuncture & Chiropractic and its affiliates to perform such procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient's Bill of Rights Statement

Patient has the right to: a considerate and respectful care and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis; the opportunity to discuss & request information related to specific procedures and/or treatments, risks involved, possible length of recuperation, and medically reasonable alternatives and their accompanying risks and benefits; know identity of providers, and others involved in his or her care, as well as when those involved are students, residents, or other trainees. Also financial implications of treatment choices, insofar as they are known; make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care. The patient also has the right to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services; privacy (discussion, consultation, examination, & treatment should be conducted to protect each patient's privacy); expect that all communications and records pertaining to his/her care will be treated confidentially, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the provider will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records; review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law; expect that, within its capacity & policies, a provider will make reasonable response to patient's request for appropriate/medically indicated care & services. Provider must provide evaluation, service, and/or referral as needed

ask and be informed of the existence of business relationships among the provider, other health care providers, or payers that may influence the patient's treatment and care; consent to or decline to participate in proposed research studies or human experimentation affecting care & treatment or requiring direct patient involvement, and to have those studies fully explained prior to consent. A patient who declines to participate in research or experimentation is entitled to effective care that provider can otherwise provide; expect reasonable continuity of care when appropriate and to be informed by providers and other caregivers of available and realistic patient care options when the current course of care is no longer appropriate; and be informed of providers' policies & practices that relate to patient care, treatment, and responsibilities. Patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. Patient has the right to be informed of the provider's charges for services and available payment methods.

Collaborative nature of healthcare requires that patients/their families/surrogates, participate in their care. Effectiveness of care & patient satisfaction with the course of treatment depend, in part, on the patient fulfilling certain responsibilities. Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision making, patients must be encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand information & instructions. Patients are responsible for informing their providers and other caregivers if they anticipate problems in following prescribed treatment. Patients should also be aware of the provider has to be reasonably efficient and equitable in providing care to other patients and the community. Patients and their families are responsible for making reasonable accommodations to the needs of the provider, other patients, staff, and employees. Patients are responsible for providing necessary information for insurance claims, when necessary. A person's health depends on more than healthcare service. Patients are responsible for recognizing impact of their life-style on their personal health.

I certify that information on these forms has been answered truthfully and completely to the best of my knowledge. I certify to the health insurance Assignment and Release statement. I certify to the Informed Consent and Patient Bill of Rights statements.

Patient/Guardian Signature

Date