BERKELEY ACUPUNCTURE PROJECT

of California, *a 501(c)(3) non-profit organization*
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New Patient Registration and Health Questionnaire

Patient Information

Date of First Visit: _____

Name: _____

Address: _____

City State Zip: _____

Age: _____ Birth Date: _____/_____/_____

Pronoun: She He They *other:*_____

Occupation: _____

Primary physician: _____

Contact Information

Best phone #_____

Alternate phone # _____

Email: _____

Another person we may contact in case of emergency:

Name/Relationship/Phone_____

_____

How did you hear about us? _____

Are you new to acupuncture? Yes____ No_____

Health Information

What are your primary concerns/complaints?

1) _____

Date started:_____ Severity:_____

2) _____

Date started:_____ Severity:_____

3) _____

Date started:_____ Severity:_____

How is your sleep? _____

How is your energy level? _____

How is your digestion? _____

_____

List medications, supplements, or herbs you are taking:

_____

_____

_____

Are you taking blood thinners? Yes_____ No_____

List serious accidents or surgeries: _____

_____

_____

Are you pregnant? Yes____ No____ _____wks

Are you interested in taking Chinese Herbs?

Yes_____ No_____ Maybe_____

Check conditions you have now or have had in the past:

☐HIV+/AIDS ☐ Anemia

☐Arthritis ☐ Asthma

☐Cancer _____

☐Autoimmune Disorder_____

☐Bleeding Disorder ☐Diabetes I or II

☐Heart disease ☐Hepatitis B or C

☐High blood pressure: Controlled? Yes No Not Sure

☐Pacemaker ☐ Stroke

☐Depression ☐ Anxiety

☐Erection difficulties ☐ Prostate trouble

☐Low libido ☐ Hemorrhoids

☐Herpes ☐ PMS

☐Fibroids ☐ Miscarriages

☐Meno/perimenopause symptoms _____

☐Severe allergies_____

☐ History of fainting or seizures_____

Is there anything else you'd like us to know about you?

_____

_____

Acupuncturist's notes: _____

_____

_____

_____

_____