Alternative Medical Clinic

Patient Registration

Name ____
Phones: Day ____________________Night __________________ Cell _____________________
Address__________________________City__________________State_____ Zip _________
Date of Birth________________ Age _________ Sex: M____ F ____Height _______ Weight _______

Employer____________________________ Occupation _______________________________
Address_______________________________ City _______________ State_______ Zip _________
Work Phone ( ) ____
Driver's License #__________________ State_____________ Exp. Date__________________
Marital Status M S D W No. of Children: Boys________ Girls ________ S.S.# ____________________
Name of Spouse__________________________ Referred by ___________________________
Spouse's employer (name, address, city, phone) ____________________________________
Person financially responsible (if patient is a child, fill out above work information etc., for parent.)
Spouse's Occupation _______________ Contact in emergency ___________ Phone______________
Medical Insurance: Yes________ No ________ Insurance Co. Name __________________________
I.D.# _________________ Group# ________________ Address _________________________
Major Medical ___________________________ Address ______________________________
Name__________________________________ Day/Night Phone( )_____________________
I.D.# _________________________________ Group# _______________________________
Name of insured_______________________ Date of Birth of insured _____________________
S.S.# of insured____

Chief Complaint: ___________________________ Secondary Complaint: _______________________

Family History

Parents living: Father (age) ____________________Mother (age) ____________________________
Brothers ______________ Sisters __________________
Is there any family history of :

Diabetes___________ Asthma ___________ Cancer ___________ Mental disease__________
Heart disease __________ Lung disease ___________ Arthritis __________ Allergies_________
Any other (specify) ____

Personal History

Childhood diseases: Measles _______________ Mumps _____________ Chicken Pox_____________
Unusual childhood diseases ____
Do you smoke? _________ How many? _________ Do you drink coffee? ________ How much? _______
Do you drink alcohol? ______________ How much? __________________
Do you take any medications?__________ List names ______________________________
Do you take any vitamins? __________________ List names ______________________________
Do you exercise? __________________ Regularly _________ Infrequently ________ Seldom_________
Are you pregnant now? __________________________ Last menstrual Period___________________
Do you have a pacemaker? ____
Hobbies if any ____

Past History

List any previous significant injuries (slips, falls, auto accidents, etc.) and give dates __________________
____

Have you had any previous back troubles? Yes ______ No ______ If yes, describe and give dates _______
____
____

List any past significant illness ____
List all operations (give dates) ____
List any known allergies ____
List all abnormalities ____
Have you seen any Acupuncturist before? Yes _______ No _______
Last physical exam ______________________________ Findings ________________________________
Have you taken X rays during the past 2 years? Yes ____ No ____ What part of your body? ____________
If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally, etc. ____________
____
____

Would you say that you are under a lot of stress? ________________ if yes, explain __________________
____

Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.__________
____

Female Do you experience any pain or discomfort before, during or after menstrual cycle? Do you experience any discomforts during the cycle week (regardless of weather you menstruate, are in menopause or have had surgical removal of all or part of the female reproductive organs or skip your periods periodically.) During the week are you “grouchy”? irritable? Have crying spells? Feel uptight, more nervous, or specify any other problems. ____
____

PAYMENT IS DUE AT THE TIME OF SERVICE

I hereby assign all medical benefits to which I am entitled, including Major Medical, Medicare, private insurance or any other health plans to Richard Hsu, L.Ac.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: ____ Date: __________________