ONE EARTH ACUPUNCTURE
231 Crosswicks Road (Suite 2)
Bordentown NJ 08505
609.298.8812

ACUPUNCTURE REGISTRATION FORM

(Please Print CLEARLY)

Today's date (m/d/yyyy):

You may fill out contact info on your computer and print, then complete these forms using a pen. Please check preferred contact phone #.

PATIENT INFORMATION

Last name:	**First:**	**Middle:**	☐ Male ☐ Female	Status: (check)	Single ☐ Married ☐ Widowed ☐ Partnered ☐ Separated ☐ Divorced ☐

Birth date: (m/d/yyyy)	**Age:**	

Street address:

P.O. box:	**City:**	**State:**	ZIP Code:

☐ **Home phone:** ( )	☐ **Cell phone:** ( )	**EMAIL address:**

How did you find One Earth Acupuncture?	☐ POCA	☐ Internet/Google	☐ Physician

☐ Family	☐ Friend	☐ located near home/work	☐ Phone book/directory	☐ Other - Please indicate:

Name of person referring you:

Occupation:	**Employer:**	**Address :**	☐ **Work phone number:** ( )

Occupational stresses

(chemical, physical, other) :

Primary Care Physician name:	Address and Group:	Phone:

Your Height:	**Weight:**	**Hair color :**	**Eye color :**

IN CASE OF EMERGENCY

Name of friend or relative: Address:	Relationship to patient:	Phone number: ( )	Alternate phone no.: ( )

The above information is true to the best of my knowledge.
I understand that I am financially responsible for payment to One Earth Acupuncture at the time services are rendered.

I acknowledge that I need to provide 24hours notification for cancellations and appointment rescheduling or pay the $25.00 fee.

I authorize One Earth Acupuncture to contact me at the primary phone number and address listed above. In accordance with NJ law, THE ACUPUNCTURIST AT ONE EARTH ACUPUNCTURE ADVISES YOU TO SEE A LICENSED PHYSICIAN REGARDING YOUR CONDITION.

Signature : _____ ***Date*** _____

(For Guardian Print Name and Signature)

❑ Check here if you DO NOT wish to receive the One Earth Acupuncture Newsletter by email.

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ACUPUNCTURE HEALTH QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your patient record.
Thank you for taking the time to complete this form in its entirety.

Name *(First, Last M.I.):*	**DOB:**	**AGE:**

Have you received: ☐ Acupuncture ☐ Chinese Herbs When?	Are you currently seeing the following:	☐ Chiropractor ☐ Massage Therapist ☐ Other (please list)	☐ Naturopath ☐ Physiotherapist

List the reason for your visit today and include when the condition began:

Have you been given a diagnosis by a physician? ☐ No ☐ Yes If yes, please describe.

List other complaints for which you seek treatment (if there are multiple complaints, place a number next to each indicating priority).

Surgeries

Year	Reason	List any complications

List other hospitalizations, cosmetic surgeries, traumas :

Year	Reason	List any complications

Have you ever been diagnosed with the following? (add specific condition and year diagnosed)

☐ Allergies :	☐ Epilepsy	☐ Pelvic Inflammatory Disease
☐ Asthma	☐ Epstein Barr	☐ Rheumatic Fever
☐ AIDS/HIV	☐ Glaucoma	☐ Scoliosis
☐ Arthritis	☐ Heart Disease	☐ Seizures
☐ Anemia :	☐ Herpes :	☐ Thyroid Disease
☐ Cancer :	☐ Hepatitis :	☐ Tuberculosis
☐ Coronary Artery Disease	☐ High Blood Pressure	☐ **PACEMAKER**
☐ Crohn's / IBS (circle one)	☐ Mental Illness	☐ Other :
☐ COPD :	☐ Multiple Sclerosis	☐ Other :
☐ Diabetes :	☐ Osteoporosis	☐ Other :

Name: _____

List your prescribed medications, over-the-counter medications, and vitamins.		
Medication - Dose - Frequency Taken	**DURATION** (how many months/years)	Prescribing Physician *(PCP, cardiologist, etc.)*
ALLERGIES to medications or FOOD (list medication and specific reaction):		

LIFESTYLE

Exercise	☐ Sedentary (No exercise)		☐ Mild exercise (recreation or activity at work)			
	☐ Regular exercise (approx. 4x/week for 30 min.)		☐ Vigorous exercise (at least 5 days/week for 60 minutes)			
	Comment:					
Diet	Are you dieting? If yes, describe (self-directed, physician prescribed, etc.):				☐ Yes	☐ No
	Number of meals you eat in an average day?					
	Preferred Flavor (choose one): ☐ Bitter ☐ Salty ☐ Sweet ☐ Spicy ☐ Sour					
	Preferred Beverage :	☐ Hot	☐ Cold	☐ Room Temperature		
	List food restrictions:					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	☐ Energy Drinks	
	Indicate number of cups per day.					
Alcohol	Do you drink alcohol? ☐ Yes		☐ No			
	☐ Social Occasions Only		☐ Weekly – How many?		☐ Daily - How many?	
Tobacco	Do you currently use tobacco? ☐ Yes		☐ No	How many years?		
	☐ Cigarettes – indicate packs/day, Brand				☐ Menthol	
	☐ Cigars – number/day		☐ Pipe – number/day		☐ Chew	
	Did you use tobacco in the past? ☐ Yes		☐ No	How long ago?	For how many years?	
Drugs	Do you currently use recreational or street drugs? List:				☐ Yes	☐ No
	Have you ever used recreational or street drugs? List type and how long ago:				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	Circle the condition(s) that apply to you: painful intercourse low sex drive increased sex drive					

Name: _____

WOMEN ONLY		
Age at first menses:	Age at menopause (if applicable):	Date of last pap exam?
Typical length of bleeding (days):	Typical length of full cycle (days):	Current day of cycle:
Color of flow **(circle)** dark red bright red dark brown unknown		Clots? ☐ Yes ☐ No
(Circle applicable) Painful Heavy Bleed less than 5 days Bleed more than 5 days Spotting between periods		
Bloating Irritability Breast tenderness Bowel changes during period		
Number of pregnancies : Number of live births : Miscarriages: comment:		

Are you now pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean? List date(s):	☐ Yes	☐ No
History of urinary tract, bladder, or kidney infections? How often?:	☐ Yes	☐ No
Do you experience problems with control of urination?	☐ Yes	☐ No
Do you experience hot flashes or night sweats?	☐ Yes	☐ No
History of Fibroids? If yes, do you know size and location?	☐ Yes	☐ No
List birth control type currently used:		
History of birth control use for example use of birth control pill, when, and for how long:		

Additional comments or concerns:

MEN ONLY		
Do you experience difficulty emptying your bladder completely?	☐ Yes	☐ No
How often do you wake to urinate: Date of last prostate and rectal exam:		
Has the force of your urination recently decreased?	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Do you have a history of kidney, bladder, or prostate infection? describe:	☐ Yes	☐ No
Have you experienced blood in your urine? describe:	☐ Yes	☐ No
Do you have a history of testicular pain or swelling? describe:	☐ Yes	☐ No
Have you experienced any difficulty with erection or ejaculation? describe:	☐ Yes	☐ No

Additional comments or concerns:

Following is an extensive list of symptoms that will assist the practitioner in understanding your patterns.
Your response will assist in making your treatment more effective.
Thank you for taking the time to thoroughly complete this form.

Please read the instructions carefully:
CHECK any symptom that you REGULARLY experience. If you see a symptom that you have experienced only in the past TWO WEEKS, CIRCLE the item instead of checking it. Blank space is provided if you wish to add something not covered on this list.

☐ Fatigue after eating	☐ Chest oppression (like a belt around chest)	☐ Easily Bruise
☐ Gas after eating	☐ Stomach oppression (belt feeling below chest)	☐ Bleeding outside of the menstrual cycle
☐ Loose Stool	☐ Nausea	☐ Hernia
☐ Abdominal distention or bloating after meals	☐ Vomiting	☐ Hemorrhoids
☐ Edema	☐ Blood in urine	☐ Propensity to worry
☐ Weakness in arms and/or legs	☐ Scanty Urination	☐ Poor concentration

☐ Sweat easily (even at rest)	☐ Profuse Sweating	☐ Shortness of breath
☐ Frequent Colds	☐ Stuffed or runny nose	☐ Stiff neck
☐ Feel like you don't want to speak	☐ Temporal Headache(sides of head/temples)	☐ Coughing up phlegm
☐ Frequent cough	☐ Frontal Headache (mostly forehead)	☐ Watery Nasal Discharge
☐ Barking Cough	☐ Occipital Headache (back of head)	☐ Scratchy sore throat
☐ Dry Cough	☐ Tendency to be a perfectionist	☐ Tightness in chest
☐ Feeling of unresolved grief	☐ Tendency to hold on to things, people, emotions	

Name: _____

☐ Dizziness	☐ Sore low back	☐ Cold feeling in low back
☐ Ringing in the ears	☐ Ache in bones	☐ Cold feeling deep inside your body
☐ Vertigo	☐ Nocturnal emissions with dreams	☐ Weak legs and/or knees
☐ Deafness	☐ Dry Eyes	☐ Numbness in arms or legs
☐ Poor Memory	☐ Blurry vision	☐ Trouble starting an erection
☐ Dream disturbed sleep	☐ Copious urination that is clear	☐ Premature ejaculation
☐ Insomnia	☐ Dull headache in back of head	☐ Apathy (feeling indifferent)
☐ Malar flush (red cheeks)	☐ Dry stool	☐ Lack of willpower
☐ Mental restlessness	☐ Diarrhea first thing in the morning	☐ Infertility
☐ Night sweating or feeling very hot at night	☐ Watery diarrhea	☐ Leg edema
☐ Dry mouth at night	☐ Dribbling after urination	☐ Unwillingness to take on projects
☐ Heat in palms (hands) and soles (feet)	☐ Weak urine stream	☐ Heart palpitations, including flutters

☐ Urinary incontinence	☐ Chronic diarrhea	☐ Rapid or weak breathing
☐ Feeling like you have to urinate (but can't)	☐ Feeling like you don't want to speak	☐ Difficulty inhaling
☐ Chronic vaginal discharge	☐ Reduced sexual drive	☐ Cold sweats
☐ Premature graying hair	☐ Premature hair loss	☐ Tooth problems/loose teeth
☐ Tightness in chest above stomach	☐ Dark urine and very little comes out	☐ Tendency to have angry outbursts
☐ Overly fearful	☐ Addicted to adrenaline	☐ Feeling empty or depleted

☐ Overly organized	☐ Unorganized	☐ Feeling aimless in life
☐ Frequent sighing	☐ Headache in temples, behind eyes	☐ Ringing in ears
☐ Hiccups	☐ Sensation of heat rising or heat in head	☐ Red eyes
☐ Depression	☐ Vaginal or genital itching	☐ Alternating constipation and diarrhea
☐ Sour regurgitation or acid reflux	☐ Pain, redness or swelling of scrotum	☐ Constipation – stool formed like little balls
☐ Poor appetite	☐ Full sensation above bladder radiating down	☐ Dry hair or skin, brittle nails
☐ Belching	☐ Pain in low abdomen/bladder better w warmth	☐ Seeing spots in front of eyes (floaters)
☐ Nausea and/or vomiting	☐ Nosebleeds	☐ Blurred vision
☐ Borborygmus (stomach growling/rumbling)	☐ Purple nails, lips or skin	☐ Insomnia
☐ Feeling like there is a lump in your throat	☐ Often irritable or frustrated	☐ Wake from dream feeling frightened
	☐ Tics and/or tremors	☐ Muscle spasms or cramps

☐ Often feeling confused	☐ Often feeling scattered	☐ Laughing or crying for no reason
☐ Heart palpitations or flutters	☐ Sores in the mouth or on the tongue	☐ Difficulty remembering things
☐ Fatigue	☐ Feeling agitated or restless	☐ Feeling easily startled
☐ Anxiety	☐ Sleep trouble – dream disturbed sleep	☐ Muttering to yourself
☐ Feeling uneasy	☐ Feeling 'out of it'	☐ Agitation or shouting
Additional Comments:		