

Manchester Acupuncture Studio, LLC

Health History & Registration

Date: ____ / ____ / ____

| | | | | | | | | |
|----------------------------------|--|--------------------------------|-------|---|--------|-----------------|-----------|--|
| Name: | | | | Sex: | | Age: | | |
| Address: | | | City: | | State: | | Zip Code: | |
| Home Phone #: | | Other Phone #: Work Cell Other | | Email: | | | | |
| Date of Birth: | | Time of Birth: | | City of Birth: | | State of Birth: | | |
| Height: | | Weight: | | Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other : _____ | | | | |
| Employer: | | | | Occupation: | | | | |
| Physician: | | | | Physician's Phone #: | | | | |
| How did you hear of our clinic?: | | | | Have you been treated by Acupuncture or Oriental Medicine Before? <input type="checkbox"/> No <input type="checkbox"/> Yes ____ / ____ / ____ | | | | |

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1
10

2

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1
10

3

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1
10

HEALTH HISTORY

Circle the ↑ if you have / had the condition and note the year it started.
 Circle the ### if there is a family history of the condition.

| | YOU | Year | FAMILY | | YOU | Year | FAMILY |
|---------------------|-----|-------|--------|--------------------|-----|-------|--------|
| Cancer type(s)? | ↑ | _____ | ### | Osteoporosis | ↑ | _____ | ### |
| Diabetes | ↑ | _____ | ### | Herpes | ↑ | _____ | ### |
| Hepatitis | ↑ | _____ | ### | AIDS / HIV | ↑ | _____ | ### |
| High Blood Pressure | ↑ | _____ | ### | Other STD | ↑ | _____ | ### |
| Heart Disease | ↑ | _____ | ### | Rheumatic Fever | ↑ | _____ | ### |
| Stroke | ↑ | _____ | ### | Alcoholism | ↑ | _____ | ### |
| Seizure Disorder | ↑ | _____ | ### | Allergies type(s)? | ↑ | _____ | ### |
| Thyroid Disease | ↑ | _____ | ### | Mental Illness | ↑ | _____ | ### |
| Asthma | ↑ | _____ | ### | Kidney Disease | ↑ | _____ | ### |
| Pacemaker | ↑ | _____ | ### | Anemia | ↑ | _____ | ### |

HABITS

Amount / Week If Quit, Year?

Coffee / Tea _____

Soda _____

Tobacco _____

Alcohol _____

Drugs _____

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
 If so, what and how often:

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
 Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGURIES

Please note what happened to what body area and when it occurred (incl. dental)