WAI ACUPUNCTURE HEALTH HISTORY AND REGISTRATION

Name	Preferred Name/nickname
Full Address	Best Phone #
	Email
	❑ Male ❑ Female
Date of Birth ____ / ____ / _____	Emergency Contact Person
Occupation	Relationship
Primary Physician	Phone
How did you hear about us?	
Have you had acupuncture before?	

HEALTH HISTORY

Please list chief complaints	Level of Pain: 1-10	ALLERGY
1.		
2.		
3.		

CHECK ALL THAT APPLY:

❑ Depression	❑ Poor Sleep	❑ Bleeding Disorders	❑ Cancer-currently
❑ Difficulty Focusing	❑ Headaches	❑ Allergies	❑ Palpitations
❑ Dizziness	❑ Nervous / Irritable	❑ Hepatitis	❑ Pacemaker
❑ Easily Startled	❑ Weight Loss / Gain	❑ Arthritis	❑ Blackouts
❑ Excessive Worry	❑ Lowered Libido	❑ Seizures	❑ Neuropathy
❑ Fatigue/Tiredness	❑ Overwhelmed by Life	❑ Diabetes	❑ Nausea
Excessive Fear	AIDS	❑ High/low Blood Pressure	❑ PTSD

What medications are you taking?	Please list any prior serious illnesses, accidents, or surgeries, with approximate years:
How is your digestion (indigestion, heartburn, bloating, constipation, diarrhea, etc.)?	ANY ADDITIONAL INFORMATION?

Sign_____ Date_____