Patient Registration Form

PATIENT INFORMATION

Name: ______________________________Social Security number:__________

Date of Birth:__________Age:________Sex: M / F Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address:______________________City:__________ State:______Postal Code:______

Phone:cell: __________ home: ______________ work: __________

Occupation:________________Employed by:____________________

Emergency Contact: ________________Relationship________ Phone: __________

Email : ________________Who may thank you for referring you? ______________

Insurance Information

Person responsible for account: ________________ Relationship: __________

SSN:__________Date of Birth:__________ phone: ______________

Address(if different from above) : ______________________________

Insurance Company: ________________ Insurance Type ☐Health ☐Auto ☐Other ______

Effective Date:____________________ Date of Accident : __________

ID # / Policy #: __________ Group#:________Claim #: ______________

Copay: ______ Deductible ______ Amount met:______ Limitation on visits: ______/yr (used: ______)

Attorney : ______________________________ Phone: ______________

Adjustor : ______________________________ Phone: ______________

I, the undersigned certify that I(or my dependent) has insurance coverage with ______________________
Name of Insurance Company
and assign directly to Hyun Kim L.Ac,. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize release of all information necessary to secure payment of benefits. I further authorize the use of my signature on all insurance submissions. If my insurance company denies payment to the acupuncturist I understand that I am responsible to her for the full amount.

Patient Signature ______________________________ Date: __________

Main Complaint

Please identify your major health concerns

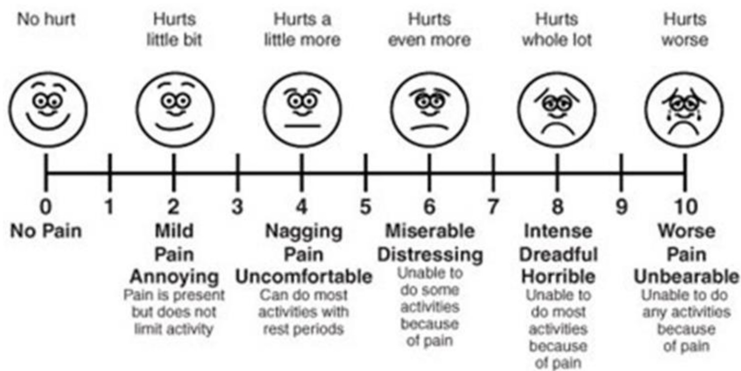
1. ____
____
How long have you had this problem? ______________________

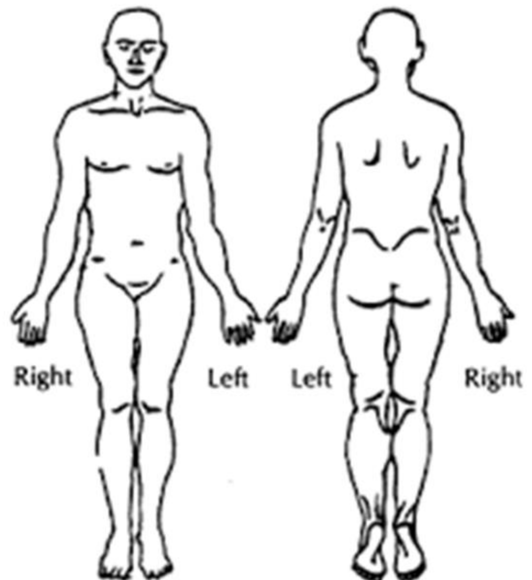
2. ____
____
How long have you had this problem? ______________________

3. ____
____

- ☐ How long have you had this problem? ______________________
- ☐ Have you been given a diagnosis for these problems? ______________________

Pain Chart





Personal Medical History *(Please include your childhood history)*

Illnesses	
Surgeries	
Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

- ☐ What other treatments have you tried and what were the outcomes? ___________________________

____

____

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Other:
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

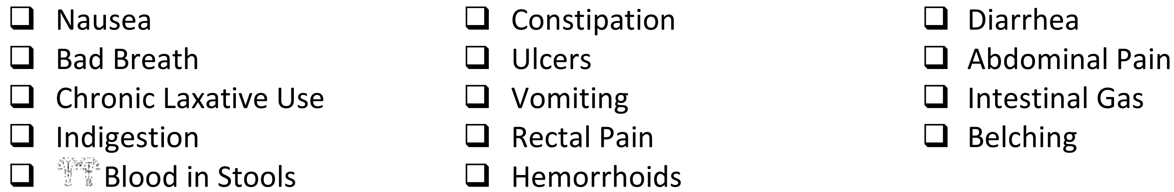
Cardiovascular

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal



- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

Gynecology

- ______ Age of Menses
- ______ Duration of Menses
- ______ Date of Last Menses
- ______ # of Pregnancies
- ______ # of Births
- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

Musculo-Skeletal

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Pain
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Muscle Cramping
- ❑ Weak Joints