The Health Connection
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

New Patient Registration Acupuncture

First Name: Middle Initial:

Last Name:

Date of Birth: / / Age: **Social Security #:**

Gender: [ ] Male [ ] Female Height: Weight:

Marital Status: [ ] Married [ ] Single [ ] Life Partner [ ] Widow(er)

Address: **City/State/Zip:**

Home Phone: **Work Phone:** **Cell Phone:**

Email:

As a courtesy, we utilize EMAIL or TEXT MESSAGE for appointment reminders for our patients. Please choose ONE.

☐ **Text message (phone number): _____ Carrier: _____**

☐ **E-mail address listed above**

Occupation: **Employer:**

Emergency Contact: Relationship & Phone:

Financially Responsible Party: [ ] Self [ ] Other-Name, Address, Phone:

Family Physician: Phone:

How did you hear about us?

Insurance Information:

If you haven't done so already, please *pre-verify* your benefits. We are not responsible for any misquote of said benefits. If we will be assisting you in billing your insurance, please fill out the following:

Name of Insurance Provider: _____

Name of Policy Holder (Primary Plan Holder): _____

Policy Holder's Date of Birth: _____

Policy Holder's Address & Phone Number:_____

Member ID Number: _____

Member ID Number: _____

Patient/Guardian Signature:_____

Date: _____

Modified: 01/21/2015

Health History Questionnaire

Reason #1 for contacting our office: _____

☐mild ☐moderate ☐severe ~ Please rate your pain on a scale of 0-10 (0 being no pain) ___/10

☐constant ☐intermittent ☐symptoms ↑ with activity ☐symptoms ↓ with activity

☐getting worse ☐getting better ☐no change

Date of Injury: _____

If no injury, when did the problem begin? _____

Reason #2 for contacting our office: _____

☐mild ☐moderate ☐severe ~ Please rate your pain on a scale of 0-10 (0 being no pain) ___/10

☐constant ☐intermittent ☐symptoms ↑ with activity ☐symptoms ↓ with activity

☐getting worse ☐getting better ☐no change

Date of Injury: _____

If no injury, when did the problem begin? _____

Reason #3 for contacting our office: _____

☐mild ☐moderate ☐severe ~ Please rate your pain on a scale of 0-10 (0 being no pain) ___/10

☐constant ☐intermittent ☐symptoms ↑ with activity ☐symptoms ↓ with activity

☐getting worse ☐getting better ☐no change

Date of Injury: _____

If no injury, when did the problem begin? _____

Have you been given a diagnosis for any of these conditions? If so, what?

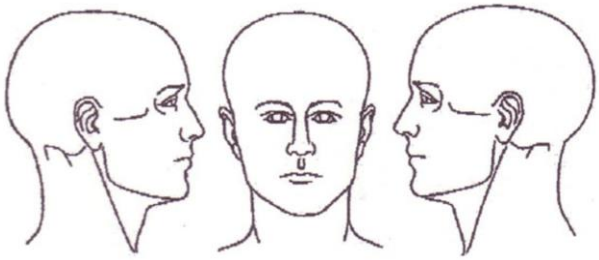
_____

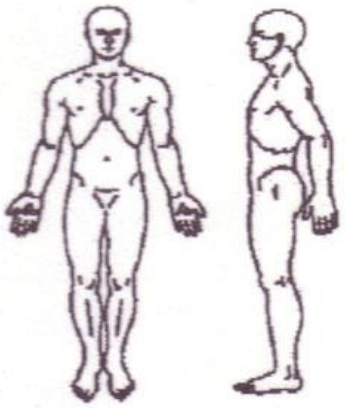
To what extent does the condition(s) interfere with your daily activity (work, exercise, sleep, sex, etc.)?_____

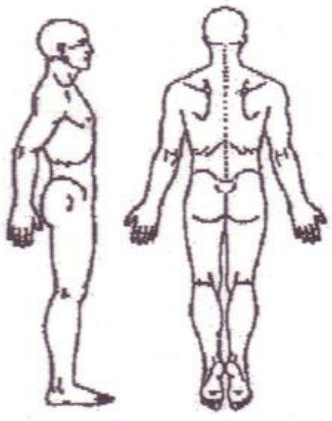
What kind of treatments have you tried?

_____

Please indicate any areas causing pain or distress:







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The Health Connection
601 South Pine Street #201 ♦ Tacoma, WA 98405 ♦ Office: (253) 396-1000 ♦ Fax: (253) 396-1012

Past Medical History:

Please note dates of each:

□ Mental Illness	□ Diabetes	□ Hepatitis	□ HIV+	□ AIDS	□ Herpes
□ High Blood Pressure	□ Heart Disease	□ Asthma	□ Allergies	□ Stroke	□ Arthritis
□ Chronic Fatigue	□ Gall Stones	□ Venereal Disease	□ Osteoporosis	□ Seizures	□ Parasites
□ Mononucleosis	□ Rheumatic Fever	□ Thyroid Problems	□ Kidney Stones	□ Ulcers	□ Cancer

□ Other _____

Surgeries (types & dates):

_____

_____

Significant Traumas:

_____

_____

Significant Dental Work:

_____

Other:

_____

Allergies (drugs, chemicals, foods, etc.)

_____

_____

Occupational Stress (chemical, physical, psychological)

_____

_____

Birth History (prolonged labor, forceps, premature, etc.)

_____

_____

Family Medical History:

□ Cancer	□ Heart Disease	□ Asthma	□ Diabetes	□ Stroke
□ Allergies	□ High Blood Pressure	□ Seizures	□ Other _____	

Medications:

What medications and/or supplements are you currently taking? _____

_____

_____

Have you had any courses of antibiotics recently? □ Many □ A few □ 1 or 2 □ None

Habits:

Do you have a regular exercise program? Please describe: _____

Usage of:

Cigarettes _____ per _____ Tea _____ per _____ Alcohol _____ per _____

Soft Drinks _____per _____ Drugs _____ per _____ Coffee _____per _____

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General

Check all that apply, and for each note if it is current or past.

□ Night Sweats □ Recurrent Infections □ Strong thirst (prefer hot or cold?) □ Fatigue
□ Sweat easily □ Bleed or bruise easily □ Thirst with no desire to drink? □ Poor Sleep
□ Overweight □ Poor Balance □ Tremors □ Edema
□ Underweight □ Sudden energy drops Time of day _____

Head/Eyes/Ears/Nose/Throat

□ Sore eyes □ Facial Pain □ Nasal discharge
□ Headaches Where _____ When _____
□ Blocked nose □ Nose bleeds □ Discharge from ear □ Migraines □ Ringing in ears
□ Hoarseness □ Snoring □ Sores on lips/mouth □ Poor hearing □ Tonsillitis
□ Dizziness □ Grinding teeth □ Recurrent sore throat □ Swollen glands □ Blurry vision
□ Eye Pain □ Color blindness □ Night blindness □ Excessive Tearing □ Squint
□ Glasses □ Teeth problems □ Spots in front of eyes □ Other _____

Skin

□ Rashes □ Itching □ Eczema □ Oozing □ Pimples □ Dry skin / scalp □ Recent moles □ Changes in hair/skin

□ Other _____

Genital-urinary

□ Pain on urination □ Urgency with urination □ Frequent urination □ Blood in urine □ Prostate problems
□ Decrease in urinary □ Unable to hold urine □ Incontinence at night □ Dribbling urination □ Kidney stones
□ Changes in sexual drive □ Rashes □ Impotency □ Other _____
□ Do you wake at night to urinate? How many times? _____

Respiratory

□ Difficulty breathing □ Pain with breathing □ Shallow breathing □ Shortness of breath □ Bronchitis
□ Production of phlegm □ Pneumonia □ Asthma/Wheezing □ Status asthmaticus □ Recurrent cough

□ Other _____

Cardiovascular

□ Pacemaker □ High Blood Pressure □ Low Blood Pressure □ Chest discomfort/pain
□ Heart Palpitations □ Cold hands or feet □ Swelling of hands or feet □ Blood Clots
□ Spider veins □ Fainting □ Other _____

Musculoskeletal

□ Neck ache/pain □ Back ache/pain □ Knee ache/pain □ Shoulder pain □ Elbow/Forearm pain
□ Hand/Wrist pain □ Foot/Ankle pain □ Joint/Bone problems □ Torn tissues □ Muscle pain/weakness
□ Prostheses □ Hernia □ Other _____

Neurological

□ Seizures □ Nerve damage □ Paralysis □ Difficulty in concentrating □ Sleep disorder □ Stroke
□ Concussion □ Loss of balance □ Vertigo □ Lack of coordination □ Poor memory

□ Other _____

Gynecological

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# of pregnancies_____ # births_____ # premature births_____
Age of 1st menses_____ # days between menses_____ Duration of menses_____ 1st day of last menses_____
Age of menopause_____ Date of last PAP_____
□ PMS □ Irregular periods □ Painful periods □ Light periods □ Heavy periods □ Clots
□ Fibroids □ Endometriosis □ Infertility □ Breast lumps □ Vaginal discharge
□ Vaginal sores □ Nipple discharge □ Postcoital bleeding □ Other _____
Do you practice birth control? □ yes □ no What type and for how long? _____
Are you pregnant now? □ yes, Due Date: _____ □ no

Digestion

□ Bad breath □ Change in appetite □ Loose stools / Diarrhea □ Heartburn □ Indigestion
□ Weight gain □ Weight loss □ Bloody stools □ Belching □ Nausea
□ Pale stools □ Abdominal pain/cramps □ Black stools □ Hemorrhoids □ Rectal pain
□ Vomiting □ Green stool □ Pain with passing stools □ Gas
□ Bulimia □ Anorexia nervosa □ Strong smelling stools □ Constipation (not daily, or difficult)

□ Other _____

Behavioral

□ Vacant □ Easily susceptible to stress □ Panic Attacks □ Anxiety □ Fear □ Depression
□ Moody □ Aggressive/Bad temper □ Lose control of emotions □ Substance abuse

□ Other _____
Have you ever been treated for emotional problems? □ yes □ no

Comments:
_____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. If you have any questions, please ask. Thank you.

Patient/Guardian Signature:_____

Date: _____

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