## Client Registration

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in this form.

**Today's Date:**

| **GENERAL INFORMATION** | Email: | | |
|---|---|---|---|
| Client Name | Date of Birth | Sex | Age |
| Parent if Client is a Minor | | Online appointment? Yes NO | |
| Client's Social Security Number | | Driver's License No. | |
| Home Address | City | State | Zip |
| Mailing Address if Different | City | State | Zip |
| Home Telephone | | Work Telephone | |
| Occupation | Employer's Name | | |
| Employer's Address | City | State | Zip |
| Spouse Name | Employer | | |
| Whom May We Thank for Referring You to Our Practice? | | | |
| | | | |
| **VISIT INFORMATION** | | | |
| Reason for Visit: | | | |
| Were You Injured on the Job? YES NO | Have You Informed Your Employer? YES NO | | |
| Is visit covered by Insurance? YES NO | (If YES, complete the Financial Information Section below.) | | |
| | (If NO, Financial Arrangement must be approved.) | | |
| | | | |
| **NOTIFY IN CASE OF EMERGENCY** | | | |
| Name | Relationship | | |
| Address | City | State | Zip |
| Home Telephone | | Work Telephone | |
| Nearest Relative (not living with you) | | | |
| Home Telephone | | Work Telephone | |
| | | | |

**Name:** _____ **Signature:** _____ **Date:** ____/____/____

**Please check the main conditions that you want treated with Acupuncture or Herbs**

| | General symptoms | | Gastro-Intestinal | | Eye/Ear/Nose/Throat | | Skin or Allergies |
|---|---|---|---|---|---|---|---|
| | Allergy | | Belching/Gas | | Thyroid Problems | | Skin Eruptions |
| | Bronchitis | | Colon Trouble | | Poor Vision | | Biols |
| | Chills | | Jaundice | | Pain in the Eyes | | Eczema |
| | Convulsions | | Nausea | | Ear Noises | | Itching |
| | Dizziness | | Vomiting | | Ear Discharges | | Dryness |
| | Fainting | | Poor Appetite | | Earache | | Hives or Allergy |
| | Fatigue | | Hiccough | | Deafness | | Sensitive Skin |
| | Fever | | Constipuation | | Frequent Colds | | **Genite- Urinary** |
| | Headache | | Diarrhea | | Sore Throat | | Kidney Infection |
| | Loss of Sleep | | Gall Bladder | | Tonsillitis | | Blood in Urine |
| | Loss of Weight | | Trouble | | Sinusitis | | Prostate Trouble |
| | Nervousiness | | Stomachache | | Hay Fever | | Bed Wetting |
| | Night Sweats | | Poor Digestion | | Asthma | | Painful Urination |
| | Numbness/pain | | Vomiting Blood | | Hoarseness | | Frequent Urination |
| | Wheezing | | | | Nose Bleeds | | Inability to Control |
| | Depression | | | | | | Uration |
| | | | | | | | |

| | Muscles & Joints | | Cardio-Vascular | | For Women Only | | Neurological |
|---|---|---|---|---|---|---|---|
| | Neck Pain | | High Blood Pressure | | Vaginal Discharge | | Bell's Palsy |
| | Backache | | Low Blood Pressure | | Painful Periods | | Epilepsy |
| | Tailbone Pain | | Slow Heart Rate | | Cramps/Backaches | | Parkinsons |
| | Stiff Neck | | Stroke | | Excessive Flow | | Placcid Paralysis |
| | Shoulder Pain | | Angina | | Hot Flashes | | Spastic Paralysis |
| | Foot Pain | | Poor Circulation | | Miscarriage | | Tinnitus |
| | Fibromyalgia | | Rapid Heart | | Overdue Pregnancy | | Tremors |
| | Twitching | | Swelling Ankles | | Breach Pregnancy | | Neuropathy |
| | Weakness | | Varicose Veins | | | | Neuralgia |
| | | | | | | | |

| | | | Respiratory | | Improvement | | |
|---|---|---|---|---|---|---|---|
| | | | Chronic Cough | | **since last visit** | | |
| | | | Spitting Blood | | 90 - 100% | | |
| | | | Spitting Phlegm | | 70 - 89% | | |
| | | | Chest Pains | | 50 - 69% | | |
| | | | Difficulty Breathing | | 40 - 50% | | |
| | | | | | 30 - 40% | | |
| | | | | | 20 - 30% | | |
| | | | | | 5 - 19% | | |
| | | | | | No Improve | | |
| | | | | | Worse | | |
| | | | | | | | |
| | | | | | | | |

# Health Distress Index

Form HDI - 40

Name or I.D.: _____ Date: _____

| | Experiences During the Past Week | Degree or Frequency of Experience | | | | |
|---|---|---|---|---|---|---|
| | Place a "✓" mark in the appropriate column: | None | Mild | Moderate | High | Highest |
| 1 | Difficulty falling asleep at night | | | | | |
| 2 | Difficulty remaining asleep at night | | | | | |
| 3 | Tired, drowsy, or fatigued during day | | | | | |
| 4 | Felt full of energy and vitality | | | | | |
| 5 | Felt agitated, tense, or restless | | | | | |
| 6 | Felt good, happy, elated | | | | | |
| 7 | Took time to engage in fun activities | | | | | |
| 8 | Socialized with people you like to be with | | | | | |
| 9 | Felt confident optimistic about things | | | | | |
| 10 | Able to work productively | | | | | |
| 11 | Felt pressed for time to complete ongoing tasks | | | | | |
| 12 | Headaches | | | | | |
| 13 | Shoulder tension or stiff neck | | | | | |
| 14 | Aches or stiffness in hands, feet, arms, or legs | | | | | |
| 15 | Back pain | | | | | |
| 16 | Pain or tightness in chest, or tenderness in breasts | | | | | |
| 17 | Abdominal pain or discomfort | | | | | |
| 18 | Nausea or vomiting | | | | | |
| 19 | Constipation, diarrhea, or flatulence | | | | | |
| 20 | Coughing or difficulty breathing | | | | | |
| 21 | Heart beats that are rapid, racing, or pounding | | | | | |
| 22 | Cold hands or cold feet | | | | | |
| 23 | Sweatiness not due to exercise or external heat | | | | | |
| 24 | Trembling, jittery, or shaking | | | | | |
| 25 | Felt dizzy, weak, or faint | | | | | |
| 26 | Felt ill, feverish, or malaise | | | | | |
| 27 | Sore throat or swollen lymph glands | | | | | |
| 28 | Undereating or low appetite | | | | | |
| 29 | Excessive overeating or binge eating | | | | | |
| 30 | Nervous or anxious | | | | | |
| 31 | Worried or apprehensive about things | | | | | |
| 32 | Difficulty concentrating or making decisions | | | | | |
| 33 | Felt inadequate, insecure, or worthless | | | | | |
| 34 | Felt down, depressed, or discouraged | | | | | |
| 35 | Felt lonely, isolated, or withdrawn | | | | | |
| 36 | Felt irritable, annoyed, or resentful | | | | | |
| 37 | Have self-critical thoughts unable to stop | | | | | |
| 38 | Crave some substance (alcohol, drugs, nicotine) | | | | | |
| 39 | Engaged in physical exercise or sports activity | | | | | |
| 40 | Have you had acupuncture treatment before | | | | | |