Welcome to *Acupuncture Plus*

A Division of Martial Arts Plus Acupuncture Equals Health, Inc.

New Patient Registration/Personal History

Let's work together to help you. To help us understand your condition, please fill out this form completely and be as neat and accurate as possible. All information is strictly confidential. Thank you. **Please Print Clearly & Neatly.**

Today's Date_____

Name_____ Gender____ Marital Status_____
Birth Date: _____/_____/_____SSN (not mandatory)_____
Address_____
City_____ State____ ZIP_____ Home Phone_____
Work Phone_____Cell Phone_____E-Mail_____
Do you want e-mail appointment reminders?_____Do you want to receive E-Newsletters?_____
Emergency Contact Name _____Relationship_____
Emergency Contact Phone Number _____
Employer's Name_____ Employer's Address_____
Employer's City_____ State____ ZIP_____ Phone_____

Family:

Name of Spouse or Parent_____ Phone #:_____

General:

How did you hear about Acupuncture Plus?_____
Previously had Acupuncture? Yes / No
What are your health concerns? Give symptoms._____
_____
_____
Duration of condition?_____ Treatment goals_____
List any allergies you have_____
List any medications you are taking_____
_____
Do you have high blood pressure?_____ Diabetes?_____ Heart Disease?_____
HIV+?_____HPV+?_____Hepatitis?_____Type_____Other?_____
Females only: Date of your last period_____ Are you pregnant?_____

Family Medical History:

☐ Allergies ☐ Arteriosclerosis ☐ Cancer ☐ Diabetes ☐ Seizures
☐ Alcoholism ☐ Asthma Explain_____ ☐ Heart Disease ☐ Stroke

I certify that the information I've given here is true and accurate to the best of my ability, including the information on the back of this form, and that services received and billed for are between me and Martial Arts Plus Acupuncture Equals Health, Inc., and that I am responsible for all fees incurred for services, even though I have other health insurance or workers compensation benefits.

Signature_____ __ Date_____

Signature of Responsible Party_____Date_____