Abundant Heaven Traditional Chinese Medicine

www.abundant-heaven.com

Patient Registration Form

Today's Date: _____

Full Name: _____

Date of Birth: _____ Hour of Birth: _____ Age: _____

Gender: Male Female Unspecified Relationship Status: _____

Occupation: _____ Hobbies/Interests: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contacts

A) Name: _____ Phone #: _____

B) Name: _____ Phone #: _____

Is the patient a minor OR does the patient require a guardian/caretaker? Y N

If Yes, list the name of the person authorizing treatment: _____

Relationship to the patient: _____

If visiting from out of town, please provide a local address and phone number:

Address: _____

Phone #: _____

How did you hear about Abundant Heaven TCM? _____

Have you ever received *Chinese medical treatment* before? If Yes, please provide your previous practitioners' names as well as the dates of treatment. Please also outline the outcomes of these treatments: *did your condition improve, worsen, or change?*

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Patient Initial Interview Form

The following document is a confidential questionnaire to determine the best possible approach and treatment plan for you. Please take your time in completing the form and provide as complete a set of information as possible. If you have any questions about the questionnaire, feel free to ask. Thank you!

Name: _____ Date: _____

Current Health Concerns

List all of the *primary health concerns* that you would like us to address: Date of onset:

_____

_____

_____

_____

_____

Have you been given any western medical diagnosis by a physician or specialist? If Yes, what was the diagnosis & when was a diagnosis made?

What other types of medical treatment or therapy have you tried (e.g. physical therapy, western herbs, massage, eneregy work, etc)?

Past Medical History

Please check those diagnosis that you have been given in the past OR are currently diagnosed with. In addition, write in any medications you are taking to control the disease pattern(s)/symptom(s):

Heart Disease:	_____	Thyroid Disease:	_____	Hepatitis:	_____
High Cholesterol:	_____	Diabetes:	_____	Alcoholism:	_____
High Blood Pressure:	_____	Drug Addiction/Use:	_____	Tuberculosis:	_____
Cancer:	_____	Types of Cancer:	_____	Other:	_____

Family Medical History

*Please check any of the following diseases that occurred in your **blood relatives** and indicate which relative was affected:*

Heart Disease:	_____	Thyroid Disease:	_____	Hepatitis:	_____
High Cholesterol:	_____	Diabetes:	_____	Alcoholism:	_____
High Blood Pressure:	_____	Drug Addiction/Use:	_____	Tuberculosis:	_____
Cancer:	_____	Mood Disorders:	_____	Other:	_____

Types of Cancer: _____

Other: _____

Patient Initial Interview Form Continued

Medications & Supplements

List all prescribed pharmaceutical medications that you are presently taking:

	Medication & Date Began Taking:	Dates:	Dosage:	Reason for Taking:
1.				
2.				
3.				
4.				
5.				

List all vitamins / supplements that you take regularly:

	Vitamin/Supplement & Date Began Taking:	Dates:	Dosage:	Reason for Taking:
1.				
2.				
3.				
4.				
5.				

List any herbs / alternative medicine(s) that you are presently taking:

	Name of Herb/Formula/Medicine(s):	Dates:	Dosage:	Reason for Taking:
1.				
2.				
3.				
4.				
5.				

Teeth & Jaw Related Information

Do you have TMJ Disorder / jaw clicking, popping and/or pain? Yes No

If Yes, how long have you experienced symptoms? _____

On which side of the jaw is the pain / clicking more noticeable? _____

Do you grind your teeth at night (Bruxism)? Yes No

Have you worn braces and/or a retainer? Yes No

If Yes, at what age did you begin wearing the braces/retainer? _____

How many years did you wear the braces/retainer? _____

Do you currently wear a retainer or mouth guard at night? Yes No

List any dental work / oral surgeries beyond regular teeth cleaning and fillings that you have had done:

Patient Initial Interview Form Continued

Lifestyle & Habits

Do you regularly consume caffeinated drinks? Yes No
If Yes, what types of drinks? _____
If Yes, how many drinks per day? _____
Do you drink alcohol? Yes No
If Yes, what types of drinks? _____
If Yes, how often & in what quantity? _____
Do you currently smoke or imbibe tobacco products? Yes No
If Yes, *how long* have you used these products? _____
If Yes, how often & in what quantity? _____
If you no longer use tobacco, *how many years did you smoke* and *when did you quit*? _____
Do you currently smoke or imbibe Cannabis products? Yes No
If Yes, *how long* have you used these products? _____
If Yes, how often & in what quantity? _____
If you smoke Cannabis, *how* do you use it? _____
Do you have a regular exercise program? Yes No
How many times a week do you exercise? _____
How much time do you spend exercising per session? _____
What type of exercise do you do? _____
Briefly describe your dietary patterns:
_____
_____
_____

Pregnancy

Are you currently pregnant? Yes No
Total # of pregnancies: _____ Have you had any miscarriages? Yes No
# of live births: _____ Have you had any premature births? Yes No

Menstruation

Date of most recent menses: _____ Length of time between menses: _____
Duration of menses (# of days): _____
Age of first menses ('menarche'): _____ Age of onset of menopause: _____
What is the date of your last gynecological examination? _____
Are you currently taking birth-control pills? Yes No
What is the name of the prescription? _____
How long have you been taking the Rx? _____

Patient Initial Interview Form Continued

List all pregnancies, births, accidents, injuries, surgeries, and hospitalizations:

	Age: & Date of Event:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

List all cosmetic procedures:

	Age: & Date of Event:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Have you ever blacked out or been knocked unconscious? Yes No
If Yes, please briefly describe the incident(s):

Please use this space to share any other relevant medical history or concerns: