



Healthpointe Acupuncture

Healing Without Side Effects. Experience You Can Trust.

50 West Edmonston Dr.
Ste. 505
Rockville, MD 20852
(210) 780-9130

REGISTRATION FORM

Please print your information to the best of your ability.

D.O.B. / /

Time of birth: : am / pm

Name

Gender: Male Female

Apt.#

City

State

Zip

Tel. (Home)

(Work)

(Cell)

Email

Primary Care Physician/Tel. #:

Occupation:

Company:

Emergency Contact:

Relationship:

Address

Tel. (Home)

(Work)

(Cell)

How did you learn about our clinic?

- Doctor's Referral Friend Healthpointe Website Sunrise Website Advertisement
 Family Other:

Please let us know if someone referred you! We would like to thank them!

Referred by: _____

Signature _____ Date _____ / _____ / _____



CONSENT TO TREATMENT

By signing below, I do hereby voluntarily consent to be treated, or give permission for my child/ward to be treated, with acupuncture or other healing techniques, health coaching, nutritional supplements, and/or substances from the Oriental Materia Medica. I understand that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners. I certify that I have informed the practitioner of all medications being used and all known physical, mental, and medical conditions, including possible pregnancy. I certify that I will notify the practitioner of any changes to these medications or health conditions.

Acupuncture & Other Techniques: I understand that acupuncture is performed by the insertion of needles through the skin with or without electrical stimulation; and/or by the application of heat to the skin at certain points on or near the surface of the body. Other techniques may also be used, which may include but are not limited to: acupressure, cupping or gua sha. I am aware that certain adverse side effects may result from treatment. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. Unusual and rare risks include nerve damage, organ puncture, and infection. I understand that I may refuse any technique or treatment offered. I understand that clean needle procedures are used in this office, and that prepackaged, sterilized needles are used once and then disposed of as medical waste.

Health Coaching: I understand that dietary/lifestyle changes, nutritional supplements and/or substances from the Oriental Materia Medica may be recommended to me as part of treatment. I understand that I am not required to follow these recommendations. I agree to follow the directions for administration and dosage if I do choose to take the recommended supplements/herbs. I am aware that certain adverse side effects may result from taking these supplements/herbs. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Healthpointe Acupuncture as soon as possible.*

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and understand the possible risk involved. I have felt free to ask any questions, and it has been satisfactorily explained to me. I understand that no guarantees concerning the use and effects of these methods are given to me and I may discontinue treatment at any time.

HIPAA: I have read and agree to Healthpointe Acupuncture's Notice of Privacy Practices.

Payment & Fees: Payment is due at the time of service. A returned check fee is charged for the first check returned by the bank. If a second check is returned, subsequent payments must be cash. We charge the full fee for treatments canceled with less than 24 hours' notice.

Signature: _____ **Date:** _____
(If under 18 years of age a parent or legal guardian must sign.)

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____



Name: _____

Date: _____

WOMEN'S HEALTH HISTORY

MAIN COMPLAINTS

Please write in your top 3 health complaints/ concerns in order of importance to you. Circle the items that make it better or worse and mark the severity of the condition on the scale from 1-10 (0=No symptoms, 10=worst ever)

#1. _____

When did this start? _____ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

0 |-----|-----|10

#2. _____

When did this start? _____ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

0 |-----|-----|10

#3. _____

When did this start? _____ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

0 |-----|-----|10

MEDICAL HISTORY

Please check off any that apply to you.

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> STD |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergies type(s):
_____ |
| <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Herpes | _____ |
| <input type="checkbox"/> Auto-immune Disease | _____ |

CURRENT MEDICATIONS

Please note what prescription medications, over-the-counter medications, herbs, or supplements you take regularly.

INJURIES / SURGERIES

Please list when & where on the body.

LIFESTYLE HABITS

amount / week If quit, year?

Coffee / Tea: _____

Soda: _____

Tobacco: _____

Alcohol: _____

Drugs: _____

EXERCISE

Do you exercise regularly?
Yes / No

If so, what & how often?

DIET

Do you follow a special diet?
(Vegetarian, Vegan, Raw, Macrobiotic, etc.)

SLEEP

of hours per night = _____

- Difficulty falling asleep
- Wake _____ x/ night @ _____ am/pm
- Wake to urinate _____ x/ night

- Disburbing dreams
- Restless sleep
- Unrested upon waking
- _____

EMOTIONS

What emotion(s) dominate your experience?

- | | | |
|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Joy |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Sadness Grief | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Timid / Shy |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Indecision |

EYE-EARS-NOSE-THROAT

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Earache | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Teeth grinding |

*** Please rate yourself on the scales below and check off any boxes that are appropriate to you. ***

TEMPERATURE			
How warm / cold do you <i>feel</i> (not in degrees); relative to other people do you wear more or less clothing, etc.?			
COLD -----		----- HOT	
<input type="checkbox"/> Cold Hands / Feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold to the bones <input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Thirst but no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Always thirsty Desire cold / hot drinks?	<input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats When _____ am / pm Where? _____	<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night
MOISTURE			
Your overall body moisture (hair, skin, mouth, etc.)?			
DRY -----		----- OILY	
<input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / nosebleeds	<input type="checkbox"/> Rashes / Hives <input type="checkbox"/> Itching <input type="checkbox"/> Edema / Swelling Where? _____	<input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss
DIGESTION			
DIARRHEA -----		----- CONSTIPATION	
BM: How often? ____ x / every ____ days(s) Are your stools well formed? Yes / No <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Fatigue after BM	<input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath	<input type="checkbox"/> Excessive hunger <input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn <input type="checkbox"/> Acid reflux	<input type="checkbox"/> Dry stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Foul smelling stool <input type="checkbox"/> Feels incomplete
ENERGY			
LOW -----		----- HIGH	
<input type="checkbox"/> Sudden energy drop <i>Time of day:</i> ____ am / pm <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Depend on caffeine/stimulants <input type="checkbox"/> Wired / Ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak <input type="checkbox"/> Bleed / Bruise easily	<input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches <i>How often?</i> ____ <input type="checkbox"/> Blood pressure High / Low	
URINARY	MENSTRUATION		
Urination= _____ x / day (<i>approx.</i>) Color= clear / light yellow / dark <input type="checkbox"/> Frequent urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Burning sensation <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Cloudy urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Dribbling <input type="checkbox"/> Difficulty starting / stopping <input type="checkbox"/> Incontinence <input type="checkbox"/> Incomplete sensation <input type="checkbox"/> Kidney stones	First period: _____ yrs. old Last period: _____ / _____ Duration _____ days Length of cycle: _____ days # of pregnancies: _____ # of births: _____ Are you sexually active? Y / N Are you pregnant? Y / N Are you on birth control? Y / N	<input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> PMS <input type="checkbox"/> Cramps <input type="checkbox"/> Clots <input type="checkbox"/> Mid-cycle spotting <input type="checkbox"/> Hot Flashes _____ x / day <input type="checkbox"/> Night-sweats _____ x / week	<input type="checkbox"/> Fatigue w/ menses <input type="checkbox"/> Fibroids <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Endometriosis <input type="checkbox"/> Herpes <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Yeast Infections <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Loss of sex drive
	MENOPAUSE		

Thank you!

We greatly appreciate your time in filling out your health history... it is the first step in enabling us to give you the most appropriate and high quality care that you will expect from our clinic.

– Healthpointe Acupuncture Staff