Pro Natural Health Center 医本堂
Email: https://sendsafe.to/pronaturalhealth.ctr@gmail.com 1-408-660-5094 (Cell)

==========

ACUPUNCTURE PATIENT REGISTRATION

Today's Date (M/D/Y): _____

Last: _____ First _____ MI ___ Sex: M ◯ F ◯

Date of Birth (M/D/Y): _____ Age _____ E-Mail: _____

Home address: _____ Apt _____

City _____State _____Zip _____ Cell Phone _____

Employer: _____ Occupation: _____

Emergency Contact Name: Last _____First _____

Emergency Phone: _____ Relation to patient: _____

How did you hear about us: Friend/Family: ☐ Google: ☐ Other: _____

INSURANCE INFORMATION: Yes ◯ No ◯

Name of insurance company: _____Insurance phone: _____

Insured's Name: _____ Date of Birth (M/D/Y) _____

Member ID: _____ Relationship to Insured: _____

Is your condition related to the following (past or current)?
Employment: Y ◯ N ◯ Worker's Comp: Y ◯ N ◯ Auto accident: Y ◯ N ◯

If you've answered "yes" to one of the above, please ask for the workers' comp/personal injury form.

CREDIT CARD (If insurance company sends checks to the member or payment is not made at the visit day):

Credit card ID: _____ Exp. Date: _____ CVC: _____

Name on the card: _____ Zip code: _____

I hereby declare that the information provided is true and correct. I also understand that I am fully responsible for any consequence caused by willful dishonesty.

Patient (Guardian) Signature: _____ Date:_____

Guardian Name: Last _____ First _____ MI _____

Pro Natural Health Center 医本堂
Email: https://sendsafe.to/pronaturalhealth.ctr@gmail.com 1-408-660-5094 (Cell)

==========

PATIENT HEALTH CONDITIONS

Patient Name: Last _____First _____ MI _____

Pain Related, where is the pain? _____

When and how did it happen? _____

(Rank the worst case)

Pain frequency: Sometimes ◯ All the time ◯ Pain ranking (1 mild – 10 severe): _____

☐ Aching ☐ Sore ☐ Squeezing ☐ Throbbing ☐ Cramping ☐ Sharp ☐ Stabbing

☐ Burning ☐ Tingling ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Electric shock

☐ Weakness ☐ Shooting Pain travels to: _____

Does the pain disturb your: ☐ sleep ☐ eating ☐ work ☐ walking ☐ daily life
☐ energy ☐ mood ☐ concentration ☐ self-care

Pain gets worse when: _____

Do you take pain killer (name, dosage & frequency): _____

Non-pain related, reason: _____

Please describe: _____

Have you seen other doctors for the above pain or non-pain related reason? Yes ◯ No ◯

If yes, when: _____ Medical exam: _____

Treatment & result _____

Other medical information: Weight _____ Height _____ Allergies: _____

HIV positive: Y◯ N◯ Hepatitis B: Y◯ N◯ Pacemaker: Y◯ N◯ Cancer: Y◯ N◯

Females: Pregnancy: Y◯ N◯ OR Last period (M/D/Y) _____

Surgery (what, where, when): _____

_____

List other medical condition:

1. _____
2. _____
3. _____
4. _____
5. _____

List any prescribed medication:

1. _____
2. _____
3. _____
4. _____
5. _____

Family medical history: _____

_____

Patient (Guardian) Signature: _____Date: _____

Guardian Name: Last _____ First _____ MI _____