

Institute of Clinical Acupuncture and Oriental Medicine
Honolulu, Hawaii

PATIENT REGISTRATION FORM

Patient Name: _____ Today's Date: _____
(LAST) (FIRST) (MI) Mo Day Year

Address: _____
Street Name (Apt #) City State Zip Code

Tel #: Home: _____ Cell: _____ Email: _____

Date of Birth: ____/____/____ Sex: M F Marital Status: S M W D
Mo Day Year

Height: ____' ____" Weight: ____ lbs. Referred by: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT: _____ Tel.#: _____

HEALTH HISTORY QUESTIONNAIRE (Confidential)

Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type		Regular Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	How Much?	
Drink Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How Much?		Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How Much?	
Coffee/ Tea	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How Much?		Hobbies or Interests			
Recent trips							

Have you previously had, or do you presently have any of the following conditions?			
<input type="checkbox"/> AIDS/HIV positive	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Others _____
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pregnant <input type="checkbox"/> Current	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	_____

PRESENT MEDICATIONS: Including Herbs & Supplements	Do you have any ALLERGIES, including to medications? <input type="checkbox"/> yes <input type="checkbox"/> no
	If yes, Please list them and the reaction you have:

Illness/injuries requiring Hospitalization or Surgery Please include reason and date	Date:

FAMILY HISTORY	
Number of: Brothers _____ Sisters _____ Children _____ Pregnancies _____	
ANY FAMILY HISTORY OF: (Check all that apply)	
<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Nervous Disorders <input type="checkbox"/> Mental Illness <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Other: (Please describe) _____	
