MICROCOSMOS ACUPUNCTURE INC.

Health History Questionnaire and Registration

PATIENT IMFORMATION

Last Name:_____First Name:_____M.I:_____

Date of Birth: (MM/DD/YYYY)____/_____/_____ Social Security Number:_____

Gender: □ Male □ Female

Home Address:_____

City _____State _____ Zip Code_____

Email:_____ Phone:_____

Emergency Contact: Name:_____ Phone:_____

Primary Physician: Name:_____ Phone:_____

Occupation:_____

Status: □ Single □ Married □ Other _____

□ Employed □ Full-time Student □ Part-time Student □ Other_____

How did you hear about us?_____

HEALTH HISTORY

What is your primary concern for your treatment? _____

When did the problem begin? _____

Please note the degree of severity of your problem now:

0 10

No problem worst Imaginable

Do you have a PACEMAKER? □ No □ Yes

Do you have any infectious diseases? □ HIV □ Hepatitis B □ Hepatitis C □ Flu

Do you have any of these diseases? □ Seizure Disorder □ Bleeding Disorder □ Fainting Disorder

□ Diabetes/Metabolic disease □ Infection □ Scarring □ Autoimmune Disease □ Morbid Obesity

□ Heart Disease □ Osteoporosis □ Stroke □ _____

Social History:

Tobacco Use: □ Non-Smoker □ Smoker ____Packs per □ day □ week

Alcohol Intake: □ Daily □ Weekly □ Occasionally □ Socially □ Seldom □ Never

Is your Condition Related To: □ Work Injury □ Auto Accident □ Other Accident

List all prescription medications you are currently taking: □ Warfarin □ Aspirin □ Other blood thinners

_____

List all surgical procedures you have had: _____

_____

Insurance Information:

Insurance Company:_____ Plan Effective Date:_____/____/_____

Member/Policy/Insured ID# _____ Policy/Plan/Group# _____

Type of the policy: □ PPO □ HMO □ POS □ Other _____

INFORMATION OF POLLICY IF OTHER THAN SELF:

Insured's Last name:_____ First Name:_____ M.I:_____

Insured's Date of Birth: _____/___/_____ Relationship:_____

Insured's Address:_____

City: _____ State: _____ Zip Code: _____

Patient / Responsible Party Name (Print): _____

Patient / Responsible Party Signature: _____ **Date:** _____/____/_____

MICROCOSMOS ACUPUNCTURE INC.

Patient Name:_____ Date: ____/____/_____

Are you under the care of physician? □ No. □ Yes, for what condition

Date of Injury:_____/____/_____

How it began: □ traumatic □ repetitive □ exacerbation □ chronic □ unknown □ postsurgical □ new incident □ _____

What Treatment have you received for the above conditions? □ Surgery □ Medications □ Injection □ MD □ Massage □ Physical Therapy □ Chiropractic □ _____

Please describe your progress: □ Worse □ Same □ 25%Better □ 50%better □ 75%better □ _____

In the past week, how much has your pain interfered with your daily activities?

□ Normal □ Mildly affected □ Severely affected □ Unable to carry on any activities

Describe your current health condition: □ Excellent □ Very good □ Good □ Fair □ Poor

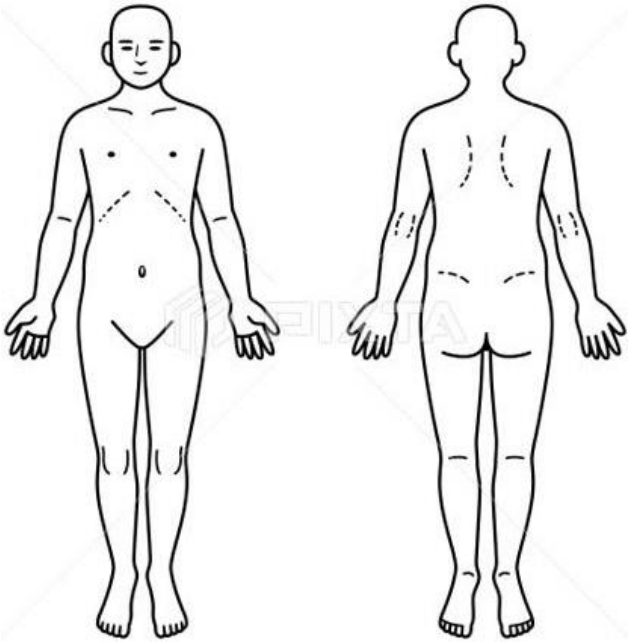
Family History: □ Arthritis □ Hypertension □ Lupus □ Mental Disorder □ Heart Disease □ Cancer

General Health History (Please check all the follow that apply to you):

Past	Present	
□	□	Alcohol/Tobacco/Drug dependence
□	□	Abnormal menstruation
□	□	Abnormal weigh loss
□	□	Allergies
□	□	Angina
□	□	Artificial joints
□	□	Asthma
□	□	Blood disorder
□	□	Breast lumps
□	□	Cancer/tumor
□	□	Pregnancy If present, # of weeks

Past	Present	
□	□	Convulsions/seizures
□	□	Diabetes
□	□	Diarrhea/constipation
□	□	Excessive thirst
□	□	Fainting or dizziness
□	□	Frequent urination
□	□	Headache
□	□	Heart attack
□	□	Heartburn or indigestion
□	□	High blood pressure

Past	Present	
□	□	Kidney
□	□	Liver problems
□	□	Pacemaker
□	□	Painful menstruation
□	□	Palpitation/arrhythmia
□	□	PMS
□	□	Prostate problems
□	□	Sinusitis
□	□	Stroke
□	□	Thyroid disease



Circle your current pain areas:

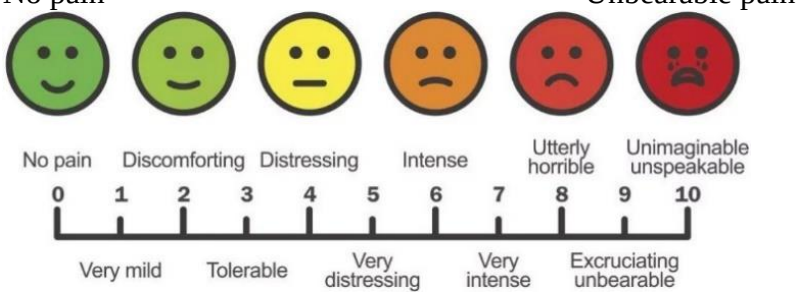
□ Head □ Neck □ Jaw
□ Chest □ Abdomen
□ Upper Back □ Middle Back □ Low Back □ Tailbone □ Hip
□ Shoulder □ Arm □ Elbow □ Wrist □ Hand
□ Thigh □ Knee □ Ankle □ Foot

The pain is:

□ Constantly □ Intermittently □ Frequently □ Occasional
□ Burning □ Stabbing □ Sharp □ Dull □ Cramping □ Shooting
□ Soreness □ Muscle Spasms □ Stiffness □ Loss of Strength

Rate your pain:

No pain Unbearable pain



Patient Signature _____ **Date** ____/____/_____

MICROCOSMOS ACUPUNCTURE INC.

❖ **Check symptoms you have had in the last three months**

General

□ Cold sensation in body
□ Cold sensation in hands and feet
□ Heavy sensation in body
□ Fatigue/tiredness
□ Spontaneous sweating
□ Night sweats
□ Bleed or bruise easily
□ Hot sensation in body
□ Hot sensation only in palms and soles
□ Hot sensation only in the afternoon
□ Thirst, liking cold drinks
□ Thirst, no desire to drink

Muscle/Joint/Bone Pain

□ Fixed pain
□ Wander pain
□ Insidious pain
□ Local burning sensation
□ Local cold sensation
□ Sudden onset
□ Stabbing pain
□ Dull pain
□ Aggravated in rainy or cloudy days
□ Aggravated at night
□ Relieved by pressure
□ Resist touch

Eyes/Ear/Nose/Throat

□ Blurred or failing vision
□ Spots in front of eyes
□ Eye dryness
□ Earache
□ Ear ringing
□ Nose bleeds
□ Nasal discharge
□ Sore throat
□ Itchy throat
□ Hoarse voice
□ Eye pain
□ Discharge from eyes
□ Excessive tear
□ Poor hearing
□ Discharge from ear
□ Nasal congestion
□ Dizziness
□ Migraines
□ Headache
□ Other _____

Skin

□ Boils
□ Dry skin
□ Itching/rash
□ Sensitive skin
□ Ulceration
□ Loss of hair
□ Other _____

Genital/Urinary

□ Clear urine
□ Yellow urine
□ Scanty urine
□ Blood/pus in urine
□ Pain on urine
□ Frequent night urine
□ Inability to control urine
□ Lowered libido
□ Weakness of lumbar and knees
□ Edema of legs
□ Burning sensation in urination
□ Difficult urination

Cardiovascular/Respiratory

□ Fullness in chest
□ Pain in chest
□ Previous heart attack
□ Rapid/irregular heart beat
□ Ankle swelling
□ Bloody phlegm
□ Cough
□ Difficulty breathing
□ Asthma/wheezing
□ Yellow phlegm
□ Clear phlegm
□ Profuse phlegm
□ Scanty phlegm

Gastrointestinal

□ Belching
□ Difficulty swallowing
□ Poor appetite
□ Excessive hunger
□ Pain over stomach
□ Bearing down sensation
□ Bitter taste in mouth
□ Lack taste in mouth
□ Sour taste in mouth
□ Hypochondria distention
□ Jaundice
□ Heartburn
□ Nausea
□ Vomiting
□ Bad breath
□ Abdominal distention
□ Blood in stools
□ Black stools
□ Dry stools
□ Loose stools
□ Smelly stools
□ Smelly gas
□ Diarrhea in early morning

Neuropsychological

□ Dream-disturbed sleep
□ Difficulty in focusing
□ Mental restlessness
□ Anxiety
□ Nervousness
□ Easy anger
□ Insomnia
□ Excess sleep
□ Poor memory
□ Depression
□ Easy sighing
□ Excessive fear
□ Irritability

For Women Only

□ Early menses
□ Delayed menses
□ Irregular menses
□ Profuse menses
□ Scanty menses
□ Clotted menses
□ Extreme menstrual pain
□ Previous miscarriage
□ Pregnant
□ Breast distending pain before menses
□ Clear and thin vaginal discharge
□ Yellow vaginal discharge
□ Smelly vaginal discharge

For Men Only

□ Erection difficulties
□ Penis discharge
□ Weak erection
□ Impotence
□ Seminal emission
□ Premature ejaculation

Patient Signature _____ **Date** _____ / / _____