Professional Acupuncture Clinic, PLLC
http://clearlakeacuhealthclinic.com
832-770-0686

Xiaoying (Elizabeth) Yuan L.Ac, M.S.
Clearlakeacuhealth@gmail.com

PATIENT REGISTRATION

Last Name _____ First Name _____ Date _____

Address _____ Zip Code _____

Telephone Home _____ Work _____ Cellular _____

Email Address _____

Age _____ DOB _____ Occupation _____

Who to reach in case of an emergency? _____

How did you hear about our clinic? _____

Are you currently receiving health care? Please circle: Y N

If yes, name of physician: _____

Condition being treated: _____

What are your most important health concerns? How long have you had this condition?

1 _____ 1 _____

2 _____ 2 _____

3 _____ 3 _____

Please list tested or suspected allergies and related symptoms:

Foods _____

Seasonal _____

Drug / other _____

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

_____

Daily Dosage _____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? _____

Do you smoke? Please circle: Y N

Office Policies

- 24-hour cancellation of appointment is required. A $25 late, cancellation, or no show fee may be charged.
- Please arrive 10 minutes prior to your appointment time. Late arrivals may result in a late cancellation fee.
- Payment is full due at the time services are rendered.

Signature _____ Date _____

(If under the age of 18, must be signed by Parent or Legal Guardian.)

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Past Medical History

Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- ☐ AIDS / HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Golter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Disease
- ☐ Other (specify): _____

List medications you are currently taking.

Medications	Strength	How many per day?	For how long?

List substances or medications you are allergic to.

List any major surgeries you have had.

Date	Problem

List significant trauma (Auto accident, falls).

List significant family history.

Your Diet

Appetite ☐ High ☐ Low

☐ Coffee ☐ Soft Drinks ☐ Artificial Sweetener

☐ Sugar ☐ Salty Food

Thirst for Water:
# of Glasses per Day: _____

Vitamins taken in the past two months: _____

Your Lifestyle

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Drugs
- ☐ Stress
- ☐ Occupational Hazards
- ☐ Regular Exercise
  Type: _____ Frequency: _____
  Type: _____ Frequency: _____

General Symptoms

- ☐ Poor Appetite
- ☐ Heavy Appetite
- ☐ Strongly like Cold Drinks
- ☐ Strongly like Hot Drinks
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Dream-disturbed Sleep
- ☐ Fatigue
- ☐ Lack of Strength
- ☐ Bodily Heaviness
- ☐ Cold Hands or Feet
- ☐ Poor Circulation
- ☐ Shortness of Breath
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweats Easily
- ☐ Muscle Cramps
- ☐ Vertigo or Dizziness
- ☐ Bleed or Bruise Easily
- ☐ Peculiar Taste (describe): _____

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☐ Glasses
☐ Eye Strain
☐ Eye Pain
☐ Red Eyes
☐ Itchy Eyes
☐ Spots in Eyes
☐ Poor Vision
☐ Blurred Vision
☐ Night Blindness

☐ Glaucoma
☐ Cataracts
☐ Teeth Problems
☐ Grind Teeth
☐ TMJ
☐ Facial Pain
☐ Gum Problems
☐ Sores on Lips or Tongue
☐ Dry Mouth

☐ Excessive Saliva
☐ Sinus Problems
☐ Excessive Phlegm
☐ Color of Phlegm: _____
☐ Recurrent Sore Throat
☐ Swollen Glands
☐ Lumps in Throat
☐ Enlarged Thyroid

☐ Nose Bleeds
☐ Ringing in Ears
☐ Poor Hearing
☐ Earaches
☐ Headaches
☐ Migraines
☐ Concussions
☐ Other Head/Neck Problems
_____

Respiratory

☐ Pneumonia
☐ Difficulty Breathing when lying down

☐ Shortness of Breath
☐ Tight Chest
☐ Asthma / Wheezing

☐ Cough
Wet or Dry? _____
Thick or Thin? _____

Color of Phlegm:
_____
☐ Coughing Blood

Cardiovascular

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Blood Clots

☐ Fainting
☐ Chest Pain
☐ Difficulty Breathing

☐ Tachycardia
☐ Heart Palpitations
☐ Phlebitis

☐ Irregular Heartbeat

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Acid Regurgitation
☐ Gas
☐ Hiccups
☐ Bloating

☐ Bad Breath
☐ Diarrhea
☐ Constipation
☐ Laxative Use
☐ Black Stools
☐ Mucous in Stools

☐ Intestinal Pain or Cramping
☐ Itchy Anus
☐ Burning Anus
☐ Rectal Pain
☐ Hemorrhoids
☐ Anal Fissures

Bowel Movements:
Frequency: _____
Color: _____
Odor: _____
Texture / Form: _____
_____

Musculoskeletal

☐ Neck / Shoulder Pain
☐ Muscle Pain
☐ Upper Back Pain

☐ Lower Back Pain
☐ Joint Pain
☐ Rib Pain

☐ Limited Range of Motion
☐ Limited Use

☐ Other (describe):
_____
_____

Skin and Hair

☐ Rashes
☐ Hives
☐ Ulceration
☐ Eczema

☐ Psoriasis
☐ Acne
☐ Dandruff
☐ Itching

☐ Hair Loss
☐ Change in Hair / Skin Texture
☐ Fungal Infection

☐ Other Hair / Skin Problems:
_____
_____
_____

Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics
☐ Poor Memory

☐ Depression
☐ Anxiety
☐ Irritability
☐ Easily Stressed

☐ Abuse Survivor
☐ Considered / Attempted Suicide
☐ Seeing a Therapist
☐ Other (specify): _____

Genitourinary

☐ Pain on Urination
☐ Frequent Urination
☐ Urgent Urination
☐ Blood in Urine

☐ Incontinent
☐ Incomplete Urination
☐ Venereal Disease
☐ Bedwetting

☐ Wake to Urinate
☐ Increased Libido
☐ Decreased Libido
☐ Kidney Stones

☐ Impotence
☐ Premature Ejaculation
☐ Nocturnal Emission
☐ Other: _____

Gynecological

Age Menses Began: _____
Length of Cycle (Day 1 to Day 1)
_____
Duration of Flow: _____
Date Last Period Began:
_____

☐ Irregular Periods
☐ Painful Period
☐ Vaginal Odor
☐ Vaginal Sores
☐ Vaginal Discharge
Color: _____

Date of Last PAP:
_____
☐ Clots
☐ PMS
☐ Breast Lumps

# of Pregnancies: _____
# of Live Births: _____
# of Premature Births: _____
Age at Menopause: _____