Wellcare Chiropractic Center

Natalia Epstein, Lic. Ac, Dipl. Ac.

Registration & Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this registration and questionnaire carefully. All of your answers are completely confidential. If there is anything you wish to bring to our attention that is not provided on this form, please note it in the "Comments" section. Thank you.

Date:	Email:	
Full Name:	Age:	Birthdate:
Home Phone:	Cell/Work:	Which is Best to Reach You? Work/Cell: ____ Home: ____
Street:		City:
State:	Zip:	Marital Status:
Primary Physician:	Emergency Contact/Phone:	Referred By:
Insurance Company:	Policy #:	

Have you ever been treated by acupuncture or oriental medicine before? Y N
Main problem(S) you would like us to help you with:
How long ago did this problem begin? Please explain:
To what extent does this problem interfere with your daily activities, such as work, sleep etc?
Have you been given a diagnosis for this problem? If so, what?
What kinds of treatments have you received/tried?

PAST MEDICAL HISTORY (Please circle all applicable past/present significant illnesses below and include date):

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever Thyroid disease

Seizures Venereal Disease Other:

Surgeries:

Significant Trauma:

Allergies (drugs, chemicals, seasonal, foods):

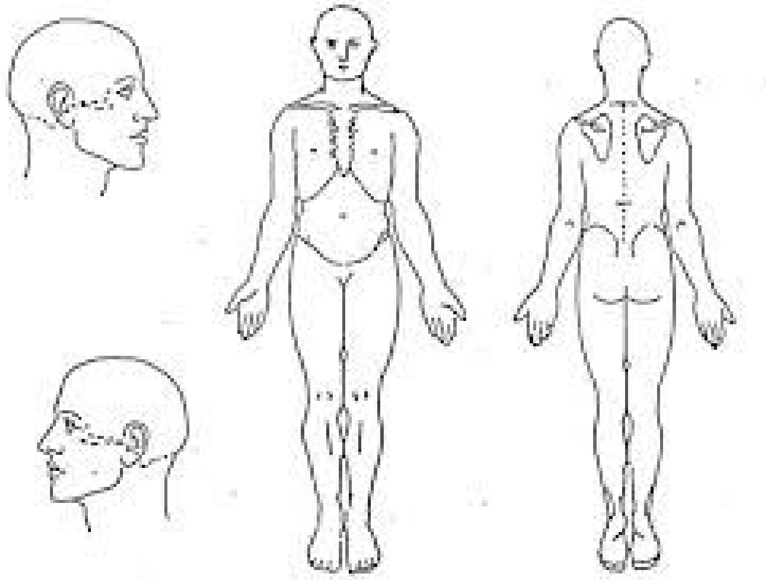
FAMILY MEDICAL HISTORY:

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Stroke Asthma

Seizures Allergies Other:

Medicines taken within the last two months (vitamins, drugs, herbs, etc.):	
Occupational Stress (chemical, physical, psychological, etc.)	
Do you have a regular exercise regimen? If yes, please describe.	
Have you ever been on a restricted diet? If yes, what kind?	
Please describe your average daily diet: Morning: Afternoon: Evening:	
How many caffeinated drinks do you have per week (tea, coffee, soda etc)?	Do you smoke? If yes, how much?
How much water do you drink per day?	How much alcohol do you drink?
Please describe any use of drugs for non-medical purposes:	

Indicate any painful or distressed area:



Please check if you have had any of the following in the last three (3) months:

___ Fevers
___ Sweat easily
___ Bleed or bruise easily
___ Peculiar tastes or smell
___ Sudden energy drop *(what time of day?):*
___ Poor sleeping
___ Chills
___ Weight loss
___ Strong thirst (hot or cold drinks)
___ Fatigue
___ Night sweats
___ Cravings
___ Change in appetite
___ Weight gain

Patient name ____________________ Date ____________

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems?
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Any other head or neck problems?
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches (where, when?)

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Any other heart or blood vessel problems?
- ☐ Low blood pressure
- ☐ Difficulty in breathing
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet

Respiratory

- ☐ Cough
- Bronchitis
- Difficulty in breathing when lying down
- Any other lung problems?
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Production of phlegm What color?
- ☐ Asthma
- ☐ Pain with a deep breath

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Any other problems with your stomach or intestines?
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Chronic laxative use
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids

Genito-Urinary

- ☐ Pain upon urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Do you wake up to urinate? How often?
- ☐ Any other problems with your genital or urinary system?
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Any particular color to your urine:
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals

Reproductive and gynecologic

- ☐ Pregnancies #:
- ☐ Live births #:
- ☐ Miscarriages #:
- ☐ Abortions #:
- Premature births #
- ☐ Age of first menses
- ☐ Period between menses
- ☐ Duration of menses
- ☐ Unusual character (heavy, light)
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Clots
- ☐ Last PAP
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Menopause Age:
- ☐
- ☐ Changes in body/psyche prior to menstruation
- ☐ Do you practice birth control? What type and for how long?

Musculoskeletal

- ☐ Neck pain
- ☐ Muscle pain
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Any other joint or bone problems?

Neuropsychological

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Areas of numbness
- ☐ Lack of coordination
- ☐ Poor memory
- Concussion
- ☐ Depression
- ☐ Anxiety
- Bad temper
- ☐ Easily susceptible to stress
- Have you ever been treated for emotional problems?
- Have you ever considered or attempted suicide?
- Any other neurological or psychological problems?

COMMENTS:

Please tell us of any other problems you would like to discuss.

Wellcare Chiropractic Center

Natalia Epstein, Lic. Ac, Dipl. Ac.

Consent to Treat

Natalia Epstein,
Licensed Acupuncturist

Consent to Treatment

I,________________________________, hereby authorize practitioner Natalia Epstein to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1) Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.

2) Heat treatments using Artemisia vulgaris (Mugwort) called moxibustion or a conventional heat lamp may be placed on or near any part of my body. For indirect moxibustion treatments, the moxa is placed on the head of the needle or on the top of a barrier (such as a slice of ginger or salt) that rests on the skin. When direct moxa is used, the moxa is placed directly on the skin. The heat generated form the moxa treatments may involve slight discomfort or leave a small blister or scar on the skin. With any type of heat, there is a risk of burn.

3) A massage technique called "gwa sha" may produce redness of the skin that remains for 1-5 days. A slight bruising or tenderness may persist following the treatment.

4) Cupping may be used to promote the circulation of Qi through the meridians. Cups may produce a red or purple color on the area cupped which may remain for 1-5 days.

5) Electrical stimulation of the needles may be used which produces a vibration sensation on the needles. Ion pumping cords may be attached to the needles.

6) Bloodletting, alone or in conjunction with cupping, may be used to improve the circulation in specific meridians. Lancets are inserted into the skin and small amounts of blood are expressed from the puncture.

I have been informed that I have a right to refuse any form of treatment. I understand the nature of the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Signature of patient:____
Printed name of patient:____
Date:____
Practitioner signature:____