Michigan Associates of
Acupuncture and
Integrative Medicine

Registration Form

Welcome to Michigan Associates of Acupuncture and Integrative Medicine

Please take a moment to provide us with some information about yourself and your health conditions so we may do our best to treat you.

Name_____

Home Phone #_____ Cell Phone #_____

Please indicate with a * which phone # you prefer us calling to confirm apts, etc...

Address_____

City_____State_____Zip_____

Sex : M F Age_____Birth Date_____

Occupation_____

Patient Employed by_____

Business Address_____

Business Phone Number_____

E-Mail Address _____

In case of an emergency, whom should we contact?

Name_____Phone #_____Relation_____

Whom may we thank for referring you?_____

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The treatment I am being given at Michigan Associates of Acupuncture and Integrative Medicine does not constitute a western medicine diagnosis. I understand that I am financially responsible for all charges. Furthermore, I understand that payment is due at the time of service and that cancellations made less than 24 hours will be charged the full rate for service.

Responsible Party **Date**

7001 Orchard Lake Road, Suite 120
West Bloomfield, MI 48322
248 | 737 | 7126

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Health History Questionnaire

Name_____ Date_____

Age_____ Date of Birth_____ Gender_____

Married__ Single__ Separated__ Divorced__ Widowed__ Partnership__

Live with: Spouse__ Partner__ Parents__ Children__ Friends__ Alone__

Please complete these next sections as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

Please list the names of any physicians or medical professionals you work with and what you are seeing them for.

Physician	Condition

What are your most important health problems? List as many as you'd like in order of importance.
1._____
_____2._____
_____3._____
_____4._____
_____5._____
_____
6._____
_____

Hospitalizations and Surgeries

What Hospitalizations, surgeries and tests (MRI, CT scan) have you had?

_____
_____
_____
_____
_____
_____

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Allergies

Are you hypersensitive or allergic to…
Any drugs?_____foods_____

Current Medications

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking. Please share the condition each medication treats and how long you have been taking the medication.

Medication	Condition	Months/years used

Overall Health

How is your sleep_____?
How is your energy_____?
Are you every dizzy or lightheaded_____?
To you tend to be hot or cold_____?
When during the day is your energy best?_____worst?_____

For the Following, Please circle

Y= a condition you have now or **P =** a condition you have had before

Head/Eyes/Neck

Headaches- **Y P**
Migraines- **Y P**
Spots in Eyes-**Y P**
Jaw/TMJ problems- **Y P**
Prior head injury- **Y P**
Ringing in the ears- **Y P**

Respiratory

Frequent colds- **Y P**
Sinus Problems - **Y P**
Shortness of breath- **Y P**
Pneumonia- **Y P**
Allergies:_____
Phlegm in throat- **Y P**
Asthma - **Y P**
Recurrent Bronchitis- **Y P**
Recurrent Sore Throats- **Y P**

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Cardiovascular

Heart Disease- **Y P**
High Blood Pressure- **Y P**
Palpitations/Fluttering- **Y P**
Angina- **Y P**
Low Blood Pressure – **Y P**
Chest pain- **Y P**

Gastrointestinal

Bowel movements How often___
is this a change_____
Abdominal Pain - **Y P**
Acid Reflux/GERD **– Y P**
Underweight – **Y P**
Normal for Height – **Y P**
Bloating **Y P**
Gas **Y P**
Bloating – **Y P**
Irritable Bowel Syndrome – **Y P**
Overweight – **Y P**
Very Overweight - **Y P**

Genitourinary

Pain on Urination- **Y P**
Frequency at night- **Y P**
Frequent infections- **Y P**
Increased frequency- **Y P**
Kidney Stones- **Y P**
Water retention- **Y P**

Endocrine/Immune

Hypothyroid- **Y P**
Hyperthyroid- **Y P**
Have you been diagnosed with an Autoimmune Disorder? _____

Skin

Musculoskeletal

Please tell us about any musculoskeletal issues
_____
_____
Where do you carry stress in your body?_____
_____
____

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Sleep

How many hours of sleep do you get on average?_____
Do you sleep well **Y N** Do you awaken rested? **Y N**

Exercise

Do you exercise? **Y N**
If yes, what kind_____How often_____

Diet

Do you eat three meals a day **Y N** Do you eat out often? **Y N**
Do you drink coffee_____ Do you eat dairy products _____
Do you drink cola____ Do you eat sugar_____

Diet, Cont.

Tell us a bit about your daily eating habits:
Breakfast_____
Lunch-_____
Dinner_____
Snacks_____
Cravings_____

Habits

Have you ever been treated for drug dependence? **Y N**
Use recreational drugs? _____ Use alcoholic beverages _____
Been treated for alcoholism _____ Do you use tobacco _____
Smoked previously _____ #packs per day____ # of years___

Lifestyle

Main interests and Hobbies_____
How many hours do you watch television? _____Read? _____
Take vacations? **Y N** Spend time outside **Y N**
Do you enjoy your work? **Y N**

Spirit

Do you have a religious or spiritual practice? Y N If yes, what?_____
Are you satisfied with your spiritual life/practice?_____

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Emotional

Treated for emotional problems- **Y P**
Mood Swings- **Y P**
Often feel angry- **Y P**
Cry Uncontrollably- **Y P**
Have a supportive relationship – **Y P**
Depression- **Y P**
Anxiety or nervousness- **Y P**
Feel Sad often- **Y P**
Irritability- **Y P**
Difficulty concentrating- **Y P**

Any major Traumas?_____

Are you currently seeing a psychologist/therapist? _____

Anything else?_____

The above information is true and accurate

_____

Signature Date

Thank you for your time

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Gynecological History

Name of Gynecologist_____
Age of first menses_____ Date of last menses_____
Are your cycles regular: Y N
Number of days between each cycle_____
Amount of bleeding: heavy medium light
Painful menses: Y N
Clotting during menses: Y N Size of clots: small medium large

PMS Symptoms_____
_____
Spotting between cycles Y N
When? How long?_____
_____

Endometriosis: Y N symptoms_____
Fibroids: Y N if yes–how many:____ size: small medium large
Have you been diagnosed with P.C.O.S.? Y N
History of ovarian cysts: Y N

Do you ovulate Y N Early: Y N Late: Y N
Do you experience pain during ovulation Y N
Do you notice cervical mucous during or prior to ovulating Y N

History of yeast infections: Y N if so, how frequent_____
History of abnormal pap smears: Y N
How is your sex drive?_____
Do you conduct self breast exams: Y N
Have you had a mammogram? Y N
Do you have fibrocystic breast disease? Y N
Have you ever used oral contraceptives? Y N
How long? When did you last use them?
_____

Are you menopausal or peri-menopausal? Y N

Symptoms_____
_____

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Gynecological History, cont.

Have you been pregnant before: Y N
How many: pregnancies_____
miscarriages_____
children_____

Have you been diagnosed with infertility? Y N
(If Yes, Please continue with the remainder of the questionnaire)

How long have you been trying to have a baby_____

Have you had ectopic pregnancies: Y N
How many_____ When_____
Are both of your tubes functioning: Y N if no, explain _____
_____
Have you had laparoscopic surgery Y N
Date_____
Outcome_____

Are you receiving care from a fertility specialist: Y N
Name_____
How long_____

Diagnosis_____
_____
_____

Have you received "alternative medicine" treatment for fertility: Y N
Explain_____
_____
_____
_____

Anything else? _____
_____
_____

The above information is true and accurate

_____
Name Date

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