



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.

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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**  
Have you been diagnosed with an Autoimmune Disorder? \_\_\_\_\_

Hyperthyroid- **Y P**

### Skin

### Musculoskeletal

Please tell us about any musculoskeletal issues

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Where do you carry stress in your body? \_\_\_\_\_

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\_\_\_\_\_



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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**

Any major Traumas? \_\_\_\_\_

Are you currently seeing a psychologist/therapist? \_\_\_\_\_

Anything else? \_\_\_\_\_

Depression- **Y P**

Anxiety or nervousness- **Y P**

Feel Sad often- **Y P**

Irritability- **Y P**

Difficulty concentrating- **Y P**

The above information is true and accurate

Signature \_\_\_\_\_

Date \_\_\_\_\_

Thank you for your time



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