PRANAJIACUPUNCTURE.COM
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Client Registration Form

Personal Information

Title: Mr.☐ Mrs.☐ Ms.☐ Miss.☐ Dr.☐

First Name: **Middle Name:** **Last Name:**

Date of Birth:

Sex: Female ☐ Male☐ Other ☐ Wt. Ht.

Contact Details

Street Address, appt., ste.,:

City: **State:** **zip:**

Home Phone: **Mobile Phone:** **Work Phone:**

Email:

Employer:

Occupation:

Emergency Contact Details

Full Name: Contact Phone Number:

Relationship to You:

Parent/Guardian (Must be completed by parent or guardian if patient is under 18):

Full Name:

Address (if Not, same as above):

Relationship (if filling for minor): Choose an item. Other (fill-in):

Health Complaints

Please list all major complaints that you help for:

Complaint Name	Date Started	Primary (Y/N)	Severity
		Yes☐ No☐	Severe☐ Moderate ☐ Slight ☐
		Yes☐ No☐	Severe☐ Moderate ☐ Slight ☐
		Yes☐ No☐	Severe☐ Moderate ☐ Slight ☐
		Yes☐ No☐	Severe☐ Moderate ☐ Slight ☐
		Yes☐ No☐	Severe☐ Moderate ☐ Slight ☐

Do these conditions impair your daily activities? Yes ☐ No ☐

If yes, explain:

Describe your symptoms:

How often do you experience your symptoms? (chose below):
Constantly (76-100% of the day): ☐
Frequently (51-57% of the day) ☐
Occasionally (26-50% of the day) ☐
Intermittently (0-25% of the day) ☐

How are your symptoms changing? Getting Better ☐ Not Changing ☐ Getting Worse ☐

What best describes the nature of your symptoms?:

Sharp ☐ Shooting ☐ Dull ache☐ Burning ☐ Numb ☐ Tingling ☐ if other, describe:

During the past 4 weeks, on a scale of 1 – 10 (1 being none and 10 being unbearable) what has been the average intensity of your symptoms?

Does anything limit you from receiving care? Yes ☐ No ☐

If yes, explain:

Other physicians/therapists you've seen for this condition(s) ?: Yes ☐ No ☐
If yes, name/contact of physicians/therapists:

Q. Have your medications or supplements ever caused you adverse side effects or problems?

YES ☐ NO ☐ If YES, please describe:

Location of Pain

Check all that applies: N/A (question not applicable) ☐

Top of Head ☐ Sides of Head ☐ Front of Head ☐
Back of Head ☐ Neck ☐ Front of Chest ☐ Back of Chest (Thoracic) ☐
Lower Back ☐ Sides of Thighs ☐ Inner Thighs ☐ knees ☐ Lower Legs ☐ Arms ☐
Hands and Wrist ☐ Left side of Body ☐ Right Side of Body ☐
Other (describe):

How much has pain interfered with your normal work (both outside the home and housework):
Not at all☐ A little bit☐ Moderately☐ Quite a bit☐ Extremely☐

How much has your condition interfered with your social activities?
Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐

In general, would you say your overall health right now is:
Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

Medication Log

Please list all medications you are currently taking – both prescription and non-prescription:

MEDICATION NAME	DATE STARTED	DATE STOPPED	DOSAGE	# PER DAY

Supplement Log

Please list all vitamins, minerals and any other nutritional supplements you are currently taking:

SUPPLEMENT NAME/BRAND	DATE STARTED	DOSE	# PER DAY	REASON FOR USE

Family & Social History

Q. Does anyone in your family or a near relative have any of the following? Please indicate whether this is on the Maternal or Paternal side of the family:

CONDITION	YES	NO	MATERNAL	PATERNAL
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Other:		__	☐	☐

Q. Have you ever been significantly exposed to any of the following through your occupation?

☐ Dust ☐ Radiation ☐ Asbestos ☐ Animals

Women Only

Regular Menstrual Cycle: YES ☐ NO ☐ Ave # of days of entire cycle:

Number of Children: Pregnant: YES ☐ NO ☐ Nursing: YES ☐ NO ☐

Age of First Menstruation: Number of Pregnancies:

Ave # of Days of Flow: Age of Menopause (if applicable):

If you are menopausal or perimenopausal: Are you taking hormone replacement therapy? YES ☐ NO ☐

Are you currently experiencing any gynaecological symptoms or problems? YES ☐ NO ☐

Do you have any history of cervical, ovarian, or breast cancer? YES ☐ NO ☐

Do you experience any of the following pre-menstrual syndromes? (Please check all that apply):

Nausea ☐ Food cravings ☐ Depression ☐ Vomiting ☐ Water Retention ☐

Headaches ☐ Irritability☐ Migraines ☐ Anxiety ☐ Breast Swelling ☐

Breast Tenderness ☐ Dull Pain (where):

Sharp Pain (where): Other:

Vaginal Discharge:	Severe ☐	Moderate ☐	Slight ☐	Normal ☐
Bleeding b/w Periods:	Severe ☐	Moderate ☐	Slight ☐	Normal ☐

Please fill out for each day of the cycle:

Day In Cycle	**1st**	**2nd**	**3rd**	**4th**	**5th**	**6th**	**7th**
Colour (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/Cramps (location, dull, sharp)							
Clots (large, small, black, purple)							
Vomiting (Check if yes)	☐	☐	☐	☐	☐	☐	☐
Nausea (Check if yes)	☐	☐	☐	☐	☐	☐	☐

Men Only

Please check under appropriate category:

Swollen Testes	Severe ☐	Moderate ☐	Slight ☐	NA ☐
Testicular Pain	Severe ☐	Moderate ☐	Slight ☐	NA ☐
Impotence	Severe ☐	Moderate ☐	Slight ☐	NA ☐
Premature Ejaculation	Severe ☐	Moderate ☐	Slight ☐	NA ☐
Coldness or numbness In external genitalia	Severe ☐	Moderate ☐	Slight ☐	NA ☐

Past Medical History

please place the age corresponding to when you experienced or first started to suffer from any of the following conditions in the past and add any comments as required:

Disease	Age	Age	Age	COMMENTS
Chicken Pox		X	X	
Measles		X	X	
Mononucleosis		X	X	
Mumps		X	X	
Whooping Cough		X	X	
Anaemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue Syndrome				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy or Convulsions				
Heart Attack/Angina				
Heart Failure				
Hepatitis				
High Blood Pressure				
Irritable Bowel				
Shingles				
Pneumonia				
Rheumatic Fever				
Sinusitis				
Stomach Illness				
Stroke				
Surgery				
Other: (describe)				

Nutrition

Q. Have you made any changes in your eating habits because of your health? YES ☐ NO ☐

Q. Do you currently follow a special diet or nutritional program? YES ☐ NO ☐

Q. What kind of diet do you eat? Please check all that apply:

☐ Mixed Food Diet (animal and vegetable foods)	☐ Low Starch/Carbohydrate
☐ High Protein Diet	☐ The Blood Type Diet
☐ Vegetarian	☐ Metabolic Typing Diet
☐ Vegan	☐ The Zone Diet
☐ Raw Foods	☐ Total Calorie Restriction
☐ Gluten Restriction	☐ Diabetic
☐ Low Sodium	☐ Sports Performance
☐ Fat Restriction	☐ Special Weight Loss Diet

Please check any specific food restrictions that you have:

☐ Dairy	☐ Soy	☐ Corn	☐ Eggs	☐ Gluten	☐ Wheat
☐ Sea Food	☐ GMO	☐ Meat Products	☐ Others:		

Q. Please, describe if there anything else special about your diet:

Lifestyle

Q. Have you ever smoked?

YES ☐ NO ☐ **If yes, how long did you smoke?** **Are you currently a smoker?** YES ☐ NO ☐

In an average week, please details how much and what type of the following you partake in:

ITEM	HOW MUCH	WHAT TYPE
CIGARETTES	cigarettes per day	
ALCOHOL	drinks per week	
RECREATIONAL DRUGS	occasions per week	
EXERCISE	occasions per week	
RELAXATION	times per week	

Overall Energy Level:

☐ Shortness of breath	☐ Difficult to keep eyes open during day	☐ Sadness
☐ Low energy	☐ Feel worse after exercise	☐ General weakness
☐ Easily catch colds	☐ Dizziness	☐ Melancholy

Other: