Bethesda Acupuncture Wellness Clinic Inc.
t/a Family Care Acupuncture & Herbal Clinic.
우리한의원 1801 Research Blvd. Ste. 220 Rockville MD 20850
T. 240.328.6608 Fax. 301.217.5993 email: wooriclinicMD@gmail.com

<Registration Form>

PERSONAL INFORMATION:

Name: _____ Gender: Male__ Female__ Unspecified __
Date of Birth:___/___/_____ Weight:_____ Height:_____
Home Address: _____
City: _____ State: _____ Zip:_____
Home Phone: _____ Work/Cell Phone: _____
To Confirm Appointments Contact me at: _____
Email: _____
Can we email you special offers, newsletters, and /or updates? Y___ N___
Emergency Contact: _____ Phone: _____
Who can we thank for referring you to our office? _____
Occupation: _____
Marital Status: Single___ Married___ Other___
Have you received Acupuncture Therapy before? Y___ N___When:___

INSURANCE/MEDICAID INFORMATION:

Insurance Co. Name: _____ Group Numbers: _____
Effective date:_____
Insurance Address: _____
City:_____ State:_____ Zip: _____
Policy#: _____ Tel#: _____

Family Medical History:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ High Blood Pressure
- ☐ Kidney/Bladder trouble
- ☐ Mental illness
- ☐ Multiple sclerosis
- ☐ osteoporosis
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Ulcers
- ☐ Pacemaker
- ☐ Other _____

Health History:

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

HABITS
- ☐ Smoking ___ Packs/day
- ☐ Alcohol ____ drinks/week
- ☐ Caffeine ____ cups/day
- ☐ High stress ____ reason

Medications (Please list below):

Medicine	Dosage	Reason	How long	Prescribed by	Date of last check up

Patient Symptoms/Conditions:

Energy & Immunity:
- ☐ Allergies
- ☐ Anemia
- ☐ Catch Colds Easily
- ☐ Fatigue
- ☐ Thyroid Problems

Mind & Emotions:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Irritability
- ☐ Mood Swings
- ☐ Vivid Dreams

Respiratory:
- ☐ Astma
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Sinus Infection
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Cold Hands/Feet
- ☐ Low Blood Pressure
- ☐ Palpitations

Ears, Nose, Throat & Eyes:
- ☐ Displeasure Taste
- ☐ Bleeding Gums
- ☐ Blurry Vision
- ☐ Dry Mouth
- ☐ Eye Dryness
- ☐ Excessive phlegm
- ☐ Fainting
- ☐ Excessive Thirst
- ☐ Frequent Sore throat
- ☐ Glaucoma
- ☐ Loss of Voice
- ☐ Nosebleeds
- ☐ Swollen Glands

Skin:
- ☐ Acne
- ☐ Brittle nails
- ☐ Changes in moles
- ☐ Cysts
- ☐ Dry hair or hair loss
- ☐ Dry itchy skin
- ☐ Easy bruising
- ☐ Eczema
- ☐ Hives
- ☐ Rashes
- ☐ Psoriasis

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Bad breath
- ☐ Belching
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Gas
- ☐ Heartburn/Acid reflux
- ☐ Hiccups
- ☐ Hemorrhoids
- ☐ Lack of appetite
- ☐ Mucus/blood in stool
- ☐ Sudden weight change

Neurological:
- ☐ Numbness
- ☐ Paralysis
- ☐ Poor memory6
- ☐ Seizures
- ☐ Tics
- ☐ Tremors
- ☐ Vertigo/dizziness

Musculoskeletal:
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Joint pain
- ☐ Muscle cramps
- ☐ Muscle spasms
- ☐ Swelling
- ☐ Tendonitis
- ☐ Weak muscles

Kidney/Urinary:
- ☐ Burning
- ☐ Edema/Swelling
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Painful urinations
- ☐ Prone to UTI

Male Health:
- ☐ Decreased libido
- ☐ Discharge from penis
- ☐ Genital itching
- ☐ Groin pain
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Prostatitis
- ☐ STD

Female Health:

Age of 1st menses ____
Date of last menses ____
Duration of flow ___ days
Length of cycle ___ days
- ☐ Heavy flow
- ☐ Light flow
- ☐ Irregular cycle
- ☐ Bleeding between periods
- ☐ Clots in menstrual blood
- ☐ Ovulation pain

PMS:
- ☐ Irritability
- ☐ Crying easily
- ☐ Breast tenderness
- ☐ Headaches
- ☐ Lower back pain
- ☐ Menstrual cramps

Current form of contraception
_____
For how long ____
# of children born ___
# of miscarriages ___
Pregnancy complications:
- ☐ Infertility

Would you like to conceive in the future (Y/N) _____
- ☐ Breast lumps
- ☐ Decreased libido
- ☐ Endometriosis
- ☐ Frequent yeast infections
- ☐ Hot flush
- ☐ Ovarian cysts
- ☐ Pcos
- ☐ Unusual vaginal discharge
- ☐ Uterine fibroids
- ☐ Vaginal dryness

Please briefly describe your symptoms:

_____

_____

_____

Any other symptoms? If so, please describe:

_____

_____

_____

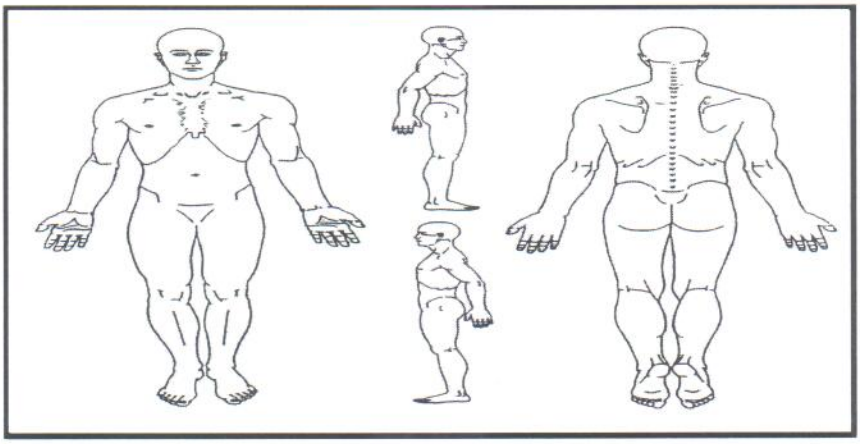
How and When did your symptoms start?:

_____

_____

_____

Please Indicate Where You have Pain or Other Symptoms:



Frequency:

How often do you experience your symptoms (circle)?:

1. **Constantly:** 76% - 100% of the time
2. **Frequently**: 51% - 75% of the time
3. **Occasionally:** 26% - 50% of the time
4. **Intermittently**: 0% - 25% of the time

Average Pain Intensity (circle):

Last 24 hours: **no pain** **1 2 3 4 5 6 7 8 9 10** **worse pain**

Past week: **no pain** **1 2 3 4 5 6 7 8 9 10** **worse pain**

What are the main health problems for which you are seeking treatment?

_____

_____

_____

List any other health problems you now have.

_____

_____

_____

List any accidents, surgeries, or hospitalizations (include date).

_____

_____

_____

Patient's Name: _____

Patient's Signature: _____

Date: _____