EASTERN MEDICINE CENTER

6782 Magnolia Avenue
Riverside, CA 92506

Adolfo Lopez, L.Ac.

REGISTRATION FORM

Today's Date	E-mail Address

PATIENT INFORMATION

PATIENT'S NAME					Marital Status (circle) Sin ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex: ☐ M ☐ F

Street Address:	Social Security No.	Home Phone No.
City: State:	Zip Code:	Cell Phone No.
Occupation: Employer:		Employer Phone No.

Referred to office by (please check one box): ☐ Insurance Plan ☐ Friend ☐ Adjuster ☐ Website ☐ Close Home/Work ☐ Family ☐ Hospital ☐ Other :

Other family members seen here: Relationship:

Referring Doctor Name: Phone Number:
Address:

Primary Care Doctor Name: Phone Number:
Address:

INSURANCE INFORMATION

Please hand the receptionist your insurance card(s) and photo ID

Primary Insurance Name: Address:	☐ Work related ☐ Auto Accident? If yes, Adjustor Name: Phone Number:				
Subscriber's Name:	Subscriber's SS No.	Birth Date:	Policy/Claim No.	Group No.	Co-Payment: $
Patient's relationship to subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other		

Secondary Insurance Name: Address:	Adjustor Name: Phone Number:				
Subscriber's Name:	Subscriber's SS No.	Birth Date:	Policy/Claim No.	Group No.	Co-Payment: $
Patient's relationship to subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other		

IN CASE OF EMERGENCY

Name of a local friend or relative (not living at same address):	Relationship to patient:	Cell / Home Phone No.	Work Phone No.

AUTHORIZATION & ASSIGNMENT OF BENEFITS: The above information is true to the best of my knowledge, I authorize my insurance benefits to be paid directly to Eastern Medicine Center. I understand that I am financially responsible for any co-payments, deductible or uncovered amounts. I also authorize Eastern Medicine Center or insurance company to release any information required to process my claims. I consent to the performance of examinations and diagnostic procedures my physician considers to be medically necessary. I authorize Eastern Medicine Center to disclose health information necessary to process claims related to my care and to other health care providers for continuing care and treatment. I have received a Notice of Privacy Practices and have been provided an opportunity to request restrictions to the use and disclosure of my health information.

Patient / Guardian Signature	Date

☐ *Copy of Insurance card (both sides attached)* *Update by:*

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Patient Last Name

First Name, Initial

What is your chief complaint?

When did these complaint begin?

Have you been diagnosed for these conditions?

Cause by: ☐ Work injury ☐ Personal injury ☐ Auto accident ☐ Fall ☐ Illness ☐ Other

Treatment(s) you have received for this condition:

Do you have pain: ☐ None ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

Describe the pain: ☐ Sharp ☐ Stabbing ☐ Dull ☐ Come and goes ☐ Electrical ☐ Tingling

Pain is worse by: ☐ Movement ☐ Resting ☐ Walking ☐ Other

Pain is better by: ☐ Movement ☐ Resting ☐ Walking ☐ Other

Do you presently received care from: ☐ MD (speciality) ☐ Dentist ☐ Chiropractor

☐ Physical Therapist ☐ Nutritionist ☐ Psychologist ☐ Other

Doctor's Name: Phone Number:

What results have been obtained?

Your condition have been ☐ Deteriorated ☐ Comes and Goes ☐ Constant ☐ Improved

Your condition interfere with: ☐ Work ☐ Daily routine ☐ Sleep ☐ Other

Have you had this condition before? Explain

What make it better:

What make it worse:

Additional information that we should know about your condition

Please mark on the diagram

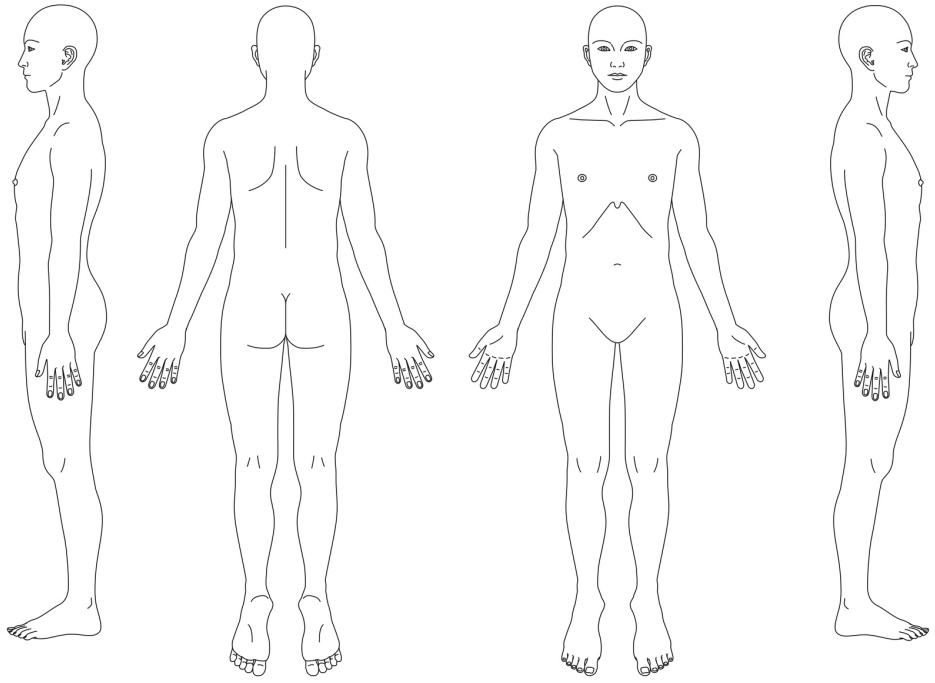
the location of the pain

Current pain level

0 1 2 3 4 5 6 7 8 9 10

Average pain level

0 1 2 3 4 5 6 7 8 9 10



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Patient Last Name

First Name, Initial

Other complaint?

Are you pregnant? ☐ Yes ☐ No Have you been pregnant with in the last six months? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How long? When did you stop smoking?

Do you or did you work with any chemical, fume, dust, smoke for prolonged periods? How long?

Date of last physical exam Have you had extensive dental or orthodontial work performed?

SURGERIES, type and date:

☐ Broken bones ☐ Concussion or head injury ☐ Dislocations ☐ Loss of consciousness

Have you ever been advice to have any surgery that has not been done? Explain

Have you been hospitalized for anything other than surgery?

DRUGS you are currently taking

Herbs, vitamins and supplements

Grade your physical health ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse

Grade your emotional health ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse

Your breakfast is ☐ Excellent ☐ Good ☐ Fair ☐ Light ☐ None

Your lunch is ☐ Excellent ☐ Good ☐ Fair ☐ Light ☐ None

Your dinner is ☐ Excellent ☐ Good ☐ Fair ☐ Light ☐ None

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Other problems you would like to discuss:

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Patient's Name
Last First

Do you bleed easily? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No

Do you faint easily or frequently? ☐ Yes ☐ No

Do you wear artificial devices? ☐ Yes ☐ No

Have you served in the military? ☐ Yes ☐ No From ____ To ____

Were you in combat? ☐ Yes ☐ No

During the day you ☐ Sit ☐ Stand ☐ Walk ☐ Desk work ☐ Phone work ☐ Drive ☐ Mechanical work ☐ Heavy lifting

Do you exercise? ☐ Daily ☐ Weekly ☐ Monthly Explain _____

Are/were you active in any particular sport(s)? ☐ Yes ☐ No Which one(s)

Grade the following potential stressors

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	past	now	past	now	past	now		past	now	past	now	past	now
Childhood stress	☐	☐	☐	☐	☐	☐	Personal relationships	☐	☐	☐	☐	☐	☐
Family stress	☐	☐	☐	☐	☐	☐	Work related stress	☐	☐	☐	☐	☐	☐
Abuse	☐	☐	☐	☐	☐	☐	Loss of love one	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐	Change in life-style	☐	☐	☐	☐	☐	☐
Family stress	☐	☐	☐	☐	☐	☐	Change in vocation	☐	☐	☐	☐	☐	☐

Have you ever had: ☐ Spinal tap ☐ Physiotherapy ☐ Chemotherapy ☐ Transfusion ☐ Extensive diag. X-rays ☐ Spinal injections ☐ Spinal brace ☐ Neck Collar ☐ Traction ☐ Corrective shoes ☐ Body part in a cast

PERSONAL HISTORY. Have you ever had or do you have have:

☐ Cancer	☐ Angina	☐ Prostate Problems	☐ Kidney disease
☐ Asthma	☐ Glaucoma	☐ Epilepsy	☐ Mental illness
☐ Arthritis	☐ Fractures	☐ Alcoholism	☐ Cardiac problems
☐ AIDS/HIV	☐ Cataracts	☐ High blood pressure	☐ Lung disease
☐ Diabetes	☐ Cirrhosis	☐ Hemorrhoids	☐ Colon problems
☐ Syphilis	☐ Dysentery	☐ Breast Disease	☐ Gonorrhea
☐ Gout	☐ Emphysema	☐ Chest pain	☐ Kidney stones
☐ Anemia	☐ Phlebitis	☐ Difficult breathing	☐ Gall B. stones
☐ Polio	☐ Varicoses	☐ Swelling ankles	☐ Tuberculosis
☐ Addition	☐ Depression	☐ Frequent urination	☐ Bronchitis
☐ Allergies	☐ Thyroid	☐ Excessive thirst	☐ Rheumatic fever
☐ Skin problems	☐ Ulcers	☐ Dry mouth	☐ Hay fever
☐ Abortion	☐ Hepatitis	☐ Autism	☐ Anorexia/Bulimia

FAMILY HISTORY. Has your father or mother ever had ('**F**' for **Father** - '**M**' for **Mother**):

☐ Cancer	☐ Allergies	☐ Alcoholism	☐ Kidney disease
☐ Asthma	☐ Glaucoma	☐ Epilepsy	☐ Mental illness
☐ Arthritis	☐ Addition	☐ Ulcers	☐ Cardiac problems
☐ Apoplexy	☐ Diabetes	☐ Tuberculosis	☐ High blood press.

Other _____ Is there any family disease tendency of which you are aware? _____

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Patient's Name

Last First

GENERAL

- ☐ Fever or chills
- ☐ Sweat easily
- ☐ Sleep problems
- ☐ Night sweats
- ☐ Bleed or bruise easily
- ☐ Loss of energy
- ☐ Excessive thirst
- ☐ Poor appetite
- ☐ Change in appetite
- ☐ Peculiar taste or smells
- ☐ Tremors
- ☐ Poor balance
- ☐ Nervousness
- ☐ Weight gain / loss
- ☐ Fatigue
- ☐ Cravings
- ☐ Hot/Cold intolerance
- ☐ Painful intercourse
- ☐ Sexual problems
- ☐ Loss of sex drive

GYNECOLOGY

- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Clots
- ☐ Cramping
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Menopause
- ☐ Hormone Replem.
- ☐ Birth control
- ☐ Vaginal discharge
- ___ No. of pregnancies
- ___ No. of miscarriages
- ___ No. of births
- ___ No. of abortions
- ___ Premature births
- ☐ _____ Last Pap

HEAD

- ☐ Dizziness
- ☐ Eyeglasses
- ☐ Loss Vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spot in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Loss of taste / smell
- ☐ Head feels heavy
- ☐ Buzzing in the ears

GENITO-URINARY

- ☐ Painful urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in the urine
- ☐ Pain in the genitals
- ☐ Wake up to urinate
- ☐ Unusual discharge
- ☐ Prostate problems/pain
- ☐ Venereal disease
- ☐ Other problems

GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in the stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Chronic laxative use
- ☐ Heartburn
- ☐ Liver problems
- ☐ Gall stones
- ☐ Colitis or diverticulitis
- ☐ Cramps

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Numbness
- ☐ Concussions
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Fainting

RESPIRATORY

- ☐ Rashes / Itching
- ☐ Dandruff
- ☐ Change skin or hair
- ☐ Ulceration
- ☐ Eczema
- ☐ Loss of hair
- ☐ Recent moles

CARDIOVASCULAR

- ☐ Painful urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in the urine
- ☐ Pain in the genitals
- ☐ Wake up to urinate
- ☐ Unusual discharge
- ☐ Prostate problems
- ☐ Venereal disease
- ☐ Other problems

MUSCULOESKELETAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/Ankle pain
- ☐ Hip pain
- ☐ Joint swelling
- ☐ Cramps

SKIN AND HAIR

- ☐ Rashes / Itching
- ☐ Dandruff
- ☐ Change skin or hair
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Urticaria
- ☐ Acne
- ☐ Edema
- ☐ Recent moles

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby requested and consent to the performance of acupuncture treatment and the other Traditional Chinese Medicine procedures, including various modes of physiotherapy on me (or on the patient named below, for who I am legally responsible) by the below name doctor, licensed acupuncturist and/or other doctor, licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a backup for the treating doctor, licensed acupuncturist named below, including those working at this clinic or other office/clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, infrared, electrical stimulation, Tuina (Traditional Chinese body work), Chinese or Western herbs, and nutritional counseling.

I have the opportunity to discuss with the acupuncturist named below and/or with other office and clinic personnel the nature and purpose of acupuncture treatment and other procedures.

Acupuncture have the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or functions of the body. I have been informed that acupuncture is a safe methods of treatment, but occasionally there may be some bruising, numbness, or tingling near the needling sites, which may last a few days. There have been very rare instances reported of fainting, infections, and scarring. There have been very rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are or come from plants, animals, and mineral sources) that have been recommended are traditionally considered safe in the practice of Traditional Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset, or allergic reactions to the herbs I will inform the office immediately.

I do not expect the acupuncturist to be able to anticipate and explain al risk and complications, and I wish to rely on the doctor, acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon facts then know, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my writing consent.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

First Last

PATIENT NAME _____ SIGNATURE _____

PATIENT REPRESENTATIVE _____ SIGNATURE _____

RELATIONSHIP _____ DATE _____