

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 <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Friend	<input type="checkbox"/> Adjuster	<input type="checkbox"/> Website	
	<input type="checkbox"/> Near Home/Work	<input type="checkbox"/> Family	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other:	
Other family members seen here:			Relationship:		
Referring Doctor's Name:			Phone Number:		
Address:					
Primary Care Doctor's Name:			Phone Number:		
Address:					
INSURANCE INFORMATION					
Please hand the receptionist your insurance card(s) and photo ID					
Primary Insurance:			<input type="checkbox"/> Work related <input type="checkbox"/> Auto Accident? If yes,		
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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance Name:			Adjustor Name:		
Address:			Phone Number:		
Subscriber's Name:	Subscriber's SS No.	Birth Date:	Policy/Claim No.	Group No.	Co-Payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 this complaint(s) begin?	Have you been diagnosed for this condition(s)?
-----------------------------------	--

Caused by: Work injury Personal injury Auto accident Fall Illness Other

Treatment(s) you have received for this condition(s):

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 receive care from: MD (specialty) Dentist Chiropractor

Physical Therapist Nutritionist Psychologist Other

Doctor's Name:

Phone Number:

What results have been obtained?

Your condition(s) has been Deteriorated Comes and Goes Constant Improved

Your condition(s) interfere with Work Daily routine Sleep Other

Have you had this condition(s) before? Explain.

What makes it better:

What makes it worse:

Additional information that we should know about your condition:

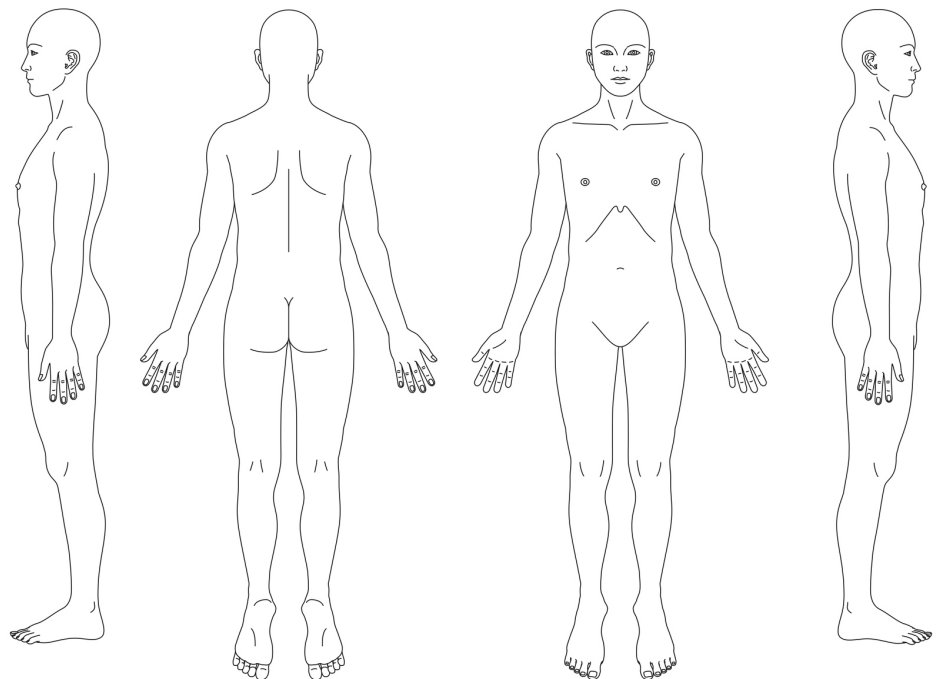
Please mark on the diagram
the location of the pain

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 complaints?

Are you pregnant? Yes No Have you been pregnant within 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 advised 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work related stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in life-style	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in vocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- | | | | |
|--|-------------------------------------|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Angina | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cardiac problems |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Colon problems |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Dysentery | <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Gallbladder stone |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Varicoses | <input type="checkbox"/> Swelling ankles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Autism | <input type="checkbox"/> Anorexia/Bulimia |

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

- | | | | |
|------------------------------------|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Addiction | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cardiac problems |
| <input type="checkbox"/> Apoplexy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> 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 of 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 throat
- 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

- Coughing
- Coughing blood
- Pneumonia
- Painful breathing
- Phlegm
- Difficulty breathing when lying down

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Dizziness
- Cold hands or feet
- Blood clots
- Leg cramps
- Swelling of hands/feet
- Phlebitis
- Chest pain
- Fainting
- Difficulty breathing
- 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 request and consent to the performance of acupuncture treatment and other Traditional Chinese Medicine procedures, including various modes of physiotherapy, on me (or on the patient named below, for whom I am legally responsible) by the above named licensed acupuncturist and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as a backup for the treating licensed acupuncturist named above, 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 had 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 has 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 method 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 all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon facts then known, 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 written 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 _____