



harmony  
traditional chinese medicine

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**Patient Registration Information**

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Personal Information:**

Name (Last, First, M.I.): \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Employer / Name of School: \_\_\_\_\_

Is your condition the result of a work injury? Y \_\_\_\_\_ N \_\_\_\_\_  
auto accident? Y \_\_\_\_\_ N \_\_\_\_\_

Spouse's Name (Last, First, M.I.): \_\_\_\_\_  
How do you wish to be addressed? \_\_\_\_\_

**Referral information:**

How were you referred to this office? \_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_



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**Confidential Patient Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Major Complaints: \_\_\_\_\_

\_\_\_\_\_

Other Complaints: \_\_\_\_\_

\_\_\_\_\_

Date of onset (when you first noticed the problem): \_\_\_\_\_

Pain or symptoms are:  Minimal  Slight  Moderate  Severe

How long have you had this condition? \_\_\_\_\_

Have you had this in the past?  Yes  No When? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Is your condition  getting worse  constant  comes and goes

Medications / drugs / herbs / supplements you are currently taking: \_\_\_\_\_

\_\_\_\_\_

List surgeries / operations you have had and dates: \_\_\_\_\_

\_\_\_\_\_

Date of your last physical exam / Doctor's visit: \_\_\_\_\_

Your primary Doctor's name, phone#: \_\_\_\_\_

**Medical History:** do you have or have you ever had?

- Arthritis  Asthma  Allergies  Anemia  Heart trouble  Cancer  Diabetes  Epilepsy  
 Kidney or bladder trouble  Gallstones  Ulcers  High blood pressure  Chronic fatigue  
 Hepatitis  Jaundice  HIV/AIDS  STDs  Sudden weight loss  Sudden weight gain  Stroke

Other: \_\_\_\_\_

**Family History:** Has any member of your family had one of the above?  Yes  No

If Yes, which member and what did they have? \_\_\_\_\_

\_\_\_\_\_