Regenia Benton LAc

NEW PATIENT REGISTRATION FORM

NAME:_____ DATE:_____
ADRESS:_____ _____
home work
_____ _____
_____ _____

PHONE:_____ _____
home work
_____ _____
cell other
EMAIL:_____

HEALTH INSURANCE#:_____
HEALTH INSURANCE PHONE#:_____
CAR ACCIDENT CLAIM#:_____

HOW DID YOU HEAR ABOUT US?_____
May we call you? Y N Only at Home/Work/Cell
May we send you mail? Y N Only at Home/Work/Cell
May we email you? Y N Only at Home/Work/Cell

FINANCIAL POLICY

I am committed to providing you with excellent and affordable health care. Payment for services and products (supplements/herbs) is due at the time of your appointment unless another arrangement has been directly with the office prior to your appointment time.

There is a 24-hour cancellation or rescheduling policy for all appointment. If you need to reschedule your appointment less than 24-hours ahead, or if you miss your appointment, you will be charged the regular fee.

All payments can be made directly to Regenia Benton in form of Cash or Check. If you have an Insurance carrier that we can bill we ask that you pay for your first session up

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front. When payment has been confirmed there will be a reimbursement at time of insurance payment. By signing below, you are agreeing to comply with this financial policy as stated above.

Confidentiality Agreement

I, Regenia Benton, owner of Blue Turtle Acupuncture understand that any information that I, my employees or subcontractors may encounter concerning patients, doctors, and staff's "protected information" will be treated as confidential.

"Protected information" means all information including health information, past, present, or future. It also includes demographic information and information that identifies a person or gives a reasonable basis to believe the information may identify that person.

I, my employees and/or subcontractors will not remove any documents or materials from the office of Blue Turtle Acupuncture, and at no time during or following my contractual agreement will I, my employees or subcontractors use or disclose any protected information. The only exclusion to this is if I contract for outcall services. I understand the importance of confidentiality and will ensure that all employees and subcontractors will be immediately reported, in writing, with an explanation of what transpired and type of reprimand given.

SIGNATURE:_____

NAME:_____

DATE:_____ DATE OF BIRTH_____

WHAT WOULD YOU LIKE TO WORK ON?

1. 3.

2. 4.

_____ _____

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HOW DO THESE CONDITIONS AFFECT YOU?

HOW LONG HAVE YOU HAD THESE CONDITIONS?

CURRENT PRESCRIPTION MEDICATIONS(Please indicate how long you have been taking them)

CURRENT OVER THE COUNTER DRUGS, SUPPLEMENTS, HERBS, VITAMINS(Please indicate how long you have been taking them)

OTHER TREATMENT MODALITIES YOU HAVE TRIED OR CURRENTLY USE TO TREAT YOUR CONDITIONS.

DO YOU HAVE A PACEMAKER? YES NO
DO YOU HAVE REASON TO BELIEVE YOU ARE PREGNANT? YES NO
DO YOU HAVE A CLOTTING DISEASE OR DISFUNCTION? YES NO
DO YOU HAVE A CHRONIC INFECTIOUS DISEASE? YES NO

TYPICAL DAILY DIET

Breakfast:

Lunch:

Dinner:

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Snacks:

Beverages:

Please list some foods you crave:

Height: **Current Weight:** **Past Maximum Weight and When:**

ALLERGIES

Environmental:

Foods:

Medications:

FAMILY HEALTH HISTORY
PLEASE CHECK ALL THAT APPLY:

	MOTHER	FATHER	SIBLING(S)	SPOUSE	CHILDREN
Health(Good, Fair, Poor)					
Age (If Living)					
If deceased, age at death					
Cause of Death					
Stroke					
Epilepsy					
Diabetes					
Arthritis					

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	MOTHER	FATHER	SIBLING(S)	SPOUSE	CHILDREN
Asthma, Hay Fever, Allergies					
High Blood Pressure					
Heart Disease					
Anemia					
Glaucoma					
Tuberculosis					
Mental Illness					
Kidney Disease					
Cancer					
Addictions					

FOR THE FOLLOWING: PLEASE CHECK ALL THAT APPLY
IF A PAST CONDITION, PLEASE INDICATE WHEN?

SKIN AND CIRCULATION	Current	Past	RESPIRATORY SYSTEM	Current	Past
Rash			Pneumonia		
Acne, Boils			Frequent Common Colds		
Eczema			Difficulty Breathing		
Hives			Emphysema		
Psoriasis			Persistent Cough		
Itching			Pleurisy		
Acute Hair Loss			Asthma		
Nail Fungus			Tuberculosis		
Cold Hands/Feet			Shortness of Breath		
			Nasal Drainage		

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SKIN AND CIRCULATION	Current	Past	RESPIRATORY SYSTEM	Current	Past
			Spitting Up Blood		

HEAD/EENT	Current	Past		Current	Past
Glasses/Contacts			Eye Pain/Strain		
Impaired Vision			Color Blindness		
Glaucoma			Cataracts		
Tearing/Dryness			Headaches		
Spots in Front of Eyes			Migraines		
Double vision			Head Injury		
Ear Ringing			Oral Thrush		
Impaired Hearing			Gum Disease		
Earaches			Dry Mouth		
Dizziness			Hoarseness		
Sinus Problems			Teeth Grinding		
Hay Fever			TMJ Jaw Problems		
Loss of Smell			Goiter/Swollen Glands		
Loss of Taste			Frequent Sore Throats		
Oral Sores			Trouble Swallowing		

EMOTIONAL	Current	Past	NEUROLOGIC	Current	Past
Mood Swings			Vertigo/Dizziness		
Depression			Paralysis		
Anxiety			Numbness/Tingling		
Considered or Attempted Suicide			Loss of Balance		
Irritability			Seizures/Epilepsy		
Unemotional					

Musculoskeletal	Current	Past	Genito-Urinary	Current	Past
Trauma or Injury					

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Musculoskeletal	Current	Past	Genito-Urinary	Current	Past
Neck/Shoulder Pain			Kindey Disease		
Upper Back Pain			Urinary Tract Infections		
Mid Back Pain			Painful Urination		
Low Back Pain			Frequent Urination		
Leg Pain			Night Urination		
Joint Pain			Imparied Urination		
Spasms Cramps			Dribbling/Incontinence		
Sprains or Strains			Blood in Urine		
Joint Surgeries			Kidney Stones		
			STD's		

Cardiovascular	Current	Past	Digestion	Current	Past
Heart Disease			Nausea		
Chest Pain			Vomiting		
Ankle Swelling			Loss of Appetite		
High Blood Pressure			Gas or Bloating		
Palpitations			Ulcer		
Stroke			Heartburn		
Heart Murmurs			Abdominal Cramping		
Rheumatic Fever			Diarrhea		
Varicose Veins			Constipation		
Fainting			Hemorrhoids		
Endocarditis			Blood or Mucous in Stool		
Phlebitis			Gallstones		

Endocrine	Current	Past	Immunity	Current	Past
Hypothyroid			Fatigue		
Hyperthyroid			Slow Wound Healing		
Hypoglycemia			Chronic Infections/Sickness		
Diabetes					
Night Sweats					
Hot/Cold Sensations					

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Women's Health	Current	Past	Women's Health	Curren	Past
Irregular Cycles			Age at First Menses		
Amenorrhea(no period)			Length of Cycle		
PMS			Duration of Cycle		
Cramping			# of Pregnancies		
Heavy Flow			# of Miscarriages		
Bleeding Between Cycles			# of Abortions		
Vaginal Discharge			# of Live Births		
Breast Lumps/Tenderness					

Women's Health	Current	Past	Men's Health	Current	Past
Menopause			Testicular Pain		
Age of Menopause			Prostate Disease or Cancer		
Polycystic Ovaries			Penile Discharge		
Uterine Fibroids			Impotency		
Endometriosis			Infertitlity Low Sperm Count		
Infertility			STD'S		
STD's					

DO YOU.....

...EXERCISE? _____ HOW OFTEN AND WHAT FORM?_____

...SLEEP WELL? _____ HOW MANY HOURS? _____

.... DRINK ALCOHOL? _____ HOW MUCH/HOW OFTEN? _____

...SMOKE OR CHEW TOBACCO?_____ HOW MUCH/HOW OFTEN? _____

(I quite tobacco: _____ I smoked this much per day: _____ for this long_____)

....DRINK CAFFEINATED BEVERAGES?_____ HOW MUCH, HOW OFTEN?_____

....USE RECREATIONAL DRUGS?_____ WHAT KIND, HOW MUCH, HOW OFTEN?_____

....SPEND TIME OUTSIDE?_____ HOW MUCH, HOW OFTEN?_____

_____ _____

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...EAT THREE MEALS A DAY?_____

...EAT OUT OFTEN?_____

...GO ON DIETS OFTEN?_____

...TAKE VACATIONS?_____

....HAVE A HISTORY OF ABUSE?_____ WHAT TYPE OF ABUSE?_____

WHAT TIME OF DAY IS YOUR ENERGY AT IT'S BEST? _____

ARE YOU SEXUALLY ACTIVE?_____

WHAT TYPE OF BIRTH CONTROL DO YOU USE?_____

CONGRATULATIONS! THANk YOU FOR TAKIN THE TIME TO FILL OUT THIS FORM!!!!!

_____ _____

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