



Integrative Medicine & Acupuncture, P.C.

PATIENT REGISTRATION FORM

NAME: DATE OF BIRTH: ADDRESS: TOWN ZIP HOME PHONE: CELL/WORK PHONE: EMAIL ADDRESS: NAME OF PRIMARY PHYSICIAN: NAME OF SPECIALISTS: Sign up for Dr. Karen's mailing list (radio show interviews/online classes etc.) YES/NO

IN CASE OF EMERGENCY, CONTACT:

Name: Relation: Home Phone: Work Phone:

HEALTH & FAMILY HISTORY

1. Do you or any of your family members have/had the following health problems?

Table with 3 columns: Health Problem, You - when diagnosed?, Family Member - who? Rows include Addictions, Allergies, Arthritis, Autoimmune Disease, Cancer, Diabetes, Digestive Problems, Drug Addiction, Eye Disease, Heart Disease, Head Injury/Falls, High Blood Pressure, High Cholesterol, Lung Disease/Asthma, Mental Health Problems, Migraine/headaches, Sinus Infections, Skin Problems, Stroke, Thyroid Disease, Other.

2. Is anyone in your immediate family deceased? If yes, please state cause of death:

3. Please list any **MEDICATION ALLERGIES** and the type of reaction you had:

4. Please list any ER visits, hospitalizations/surgeries and the approximate dates:

Reason for ER Visit/Hospitalizations/Surgeries:	Dates:

5. Please list any medications you are currently taking, including over the counter supplements, herbs and vitamins (use separate sheet of paper if needed):

Brand or Generic Name:	Dosage & Frequency:

SOCIAL HISTORY

6. Check which substances you use and describe how much you use them:

- Alcohol _____ Caffeine _____
- Tobacco _____ Quit Date: _____

7. Marital Status: _____

8. Occupation: _____

9. Spiritual Beliefs: _____

10. Number of Children, if any: _____

STRESS & SAFETY ASSESSMENT

- 11. Do you eat foods with artificial sweeteners (aspartame, Splenda)? Y N
- 12. Do you eat foods with MSG (potato chips, canned soup etc.)? Y N
- 13. On a scale of 1-10, rate the severity of your stress levels: _____
- 14. What types of mobile phones do you have in your home? _____
- 15. If you have a cordless phone, where is the base located? _____
- 16. Circle what you have in your bedroom: clock radio/cell phone/computer/television
- 17. Where are there fluorescent light bulbs in your home? _____
- 18. If you have Wi-Fi (wireless internet) at home, where is the router located? _____
- 19. If you've had a significant fall or head injury, when was it? _____
- 20. Do you consistently wear your seatbelt? Y N

Please check if you've had any of these symptoms within the last 3 weeks:

<p>General:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Sleep Difficulty <ul style="list-style-type: none"> <input type="checkbox"/> Awakenings <input type="checkbox"/> Falling asleep <input type="checkbox"/> Lack of dreaming <input type="checkbox"/> Wake up tired <input type="checkbox"/> Appetite Issues <input type="checkbox"/> Feeling Stress <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Swelling anywhere on body <p>Eye, Ear, Nose, Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eye symptoms <input type="checkbox"/> Stuffy or runny nose <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Sore Throat <input type="checkbox"/> Hearing issues <p>Lung</p> <ul style="list-style-type: none"> <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing <input type="checkbox"/> Mucus production <p>Heart</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest discomfort <input type="checkbox"/> Palpitations/skipped beats <input type="checkbox"/> Heart rhythm problems <p>Muscles/Joints</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Muscle knots/trigger points <input type="checkbox"/> Tightness/inflexibility <input type="checkbox"/> Spine issues 	<p>Brain/Nervous System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Brain fog <input type="checkbox"/> Memory Loss <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings/Irritability <input type="checkbox"/> Nerve pain <input type="checkbox"/> Tingling or Numbness <p>Reproductive Organs</p> <p>Women:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vaginal itching or discharge <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Irregular periods <input type="checkbox"/> Heavy periods +/- clots <input type="checkbox"/> PMS <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Painful sex <input type="checkbox"/> Low libido <input type="checkbox"/> Infertility <input type="checkbox"/> Inability to lose weight <input type="checkbox"/> Breast lumps or tenderness <p>Men:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low libido <input type="checkbox"/> Hair loss <input type="checkbox"/> Inability to lose weight <p>Urinary System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive urination <input type="checkbox"/> Dark urine <input type="checkbox"/> Narrow stream <input type="checkbox"/> Prostate issues (men) <input type="checkbox"/> Painful urination 	<p>Digestive System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation/hard stools <input type="checkbox"/> Diarrhea/unformed stools <input type="checkbox"/> Pale stool color <input type="checkbox"/> Blood in stool <input type="checkbox"/> Abdominal bloating <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Undigested food in stool <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Excessive gas <p>Skin/Hair/Nails</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Acne <input type="checkbox"/> Premature wrinkles <input type="checkbox"/> Premature gray hair <input type="checkbox"/> Hair Loss <input type="checkbox"/> Brittle Nails <input type="checkbox"/> "age" spots <input type="checkbox"/> Moles/Warts <input type="checkbox"/> Dry skin <p>Immune System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Environmental allergies <input type="checkbox"/> Food sensitivities <input type="checkbox"/> Frequent colds/flu <input type="checkbox"/> Swelling in legs <input type="checkbox"/> Excessive immune reaction (or autoimmune) <p>OTHER:</p>
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The purpose of this questionnaire is to assess your goals and expectations for your treatment and care. Based on what you answer, we will be more able to tailor our approach to your specific needs. **Choose the answer that best represents how you feel. Your honesty is greatly appreciated.**

Regarding your treatments, what statement best represents your interest:	<input type="checkbox"/> I'm mainly here for symptoms relief and am not interested in much else.	<input type="checkbox"/> I'd like symptom relief but also teaching on how to prevent further deterioration of my condition or how I can treat myself at home.	<input type="checkbox"/> I'd like symptom relief, but am very interested in learning a holistic approach to <i>reversing</i> the aging/illness process.
How willing are you to make lifestyle changes to heal or reverse your illness?	<input type="checkbox"/> Mostly unwilling. I just want you to fix me.	<input type="checkbox"/> Somewhat willing depending on what you'll ask of me	<input type="checkbox"/> Very willing. I'll do whatever you suggest to get better!
How quickly are you usually able to adopt new instructions and habits?	<input type="checkbox"/> Pretty slow. Just give me one new thing to do at a time.	<input type="checkbox"/> Moderate – I'm able to adopt to 2 to 3 new things/habits at a time	<input type="checkbox"/> Very quick. I am comfortable adopting new habits and therapies quickly without stress
How interested are you in discovering and/or healing the underlying causes of your illness/condition?	<input type="checkbox"/> I'd like to know if it doesn't cost too much. Mostly I want symptom relief.	<input type="checkbox"/> I'm somewhat interested in treating the cause rather than just the symptom.	<input type="checkbox"/> I'm extremely interested! Healing is a journey and I want to fully understand myself body, mind and soul. Sign me up!
How much are you willing to invest financially in regaining optimal health?	<input type="checkbox"/> I'm really looking for my health insurance to pay for most of it, so I can't invest much.	<input type="checkbox"/> If this really works for me, I'm ready to invest a certain amount to get better whether the insurance covers it all or not.	<input type="checkbox"/> My health is a major priority, so I'm willing to invest as much as I can to heal regardless of whether the insurance covers it.
Dr. Kan provides special discounts, online health classes and radio shows. How interested are you in signing up for email alerts?	<input type="checkbox"/> Not that interested. I have too many emails to read. Sorry.	<input type="checkbox"/> Somewhat interested. Sign me up to the newsletter and I'll read and/or participate in what interests me.	<input type="checkbox"/> Extremely interested! I want to be on the mailing list and learn as much as I can for free.
How open are you to the inclusion of spirituality (prayer, Angelic support etc.) in your treatments?	<input type="checkbox"/> I'm uncomfortable with prayer or discussion of God, Angels or spirits	<input type="checkbox"/> It's okay by me if it helps you be a more effective healer	<input type="checkbox"/> Extremely interested! The more help the better!

Patient/Parent Signature: _____ Date: _____

Doctor's Signature: _____

IMACUPUNCTURE POLICIES – Details of Working Together

I'm delighted we'll be working together to co-create a healthier *you*. Please review the following policies, as it will make your experience more fluid and it will help me foster excellent results for you.

The following systems are in place so as to keep us on track, focused and successful in your health goals. This includes:

- Creating the results you desire in a timely manner
 - Providing you with holistic healing recommendations based on your specific goals
 - Empowering you on how to take care of your body-mind-soul when you're not in my office
1. **Office Hours:** Please note my patient hours are Tuesday 10:00AM – 6:00PM, Wednesday 10:00-12:00 noon and 2:00 – 6PM, Friday 10:00AM – 7:00PM and Saturdays 11:00AM – 2:00PM. If you contact us during days/times other than those, we'll get back to you as soon as we can on the next business day.
 2. **Treatment Schedule:** Treatments are scheduled weekly or every two weeks for an initial five treatments after which we will decide how often you need to be treated. The best results are obtained with weekly consultations/treatments for chronic or complex conditions. You may stop your treatments at any point, but if you stop before completing an initial five treatments series within a 2 month period of time, there is less of a chance of permanent long-term improvements.
 3. **CANCELLATION POLICY:** I want the very best experience for you. Please try not to reschedule your appointments. If, however, you must reschedule, we require 24 hours' notice *by telephone* for cancellation of appointments. If you book a remote consult online you need to give at least 48 hours notice. Same-day cancellations or missed appointments will be charged the usual appointment fee. If you miss two appointments without adequate notice, we reserve the right to discharge you from the practice.
 4. **Payment Policy:** We do not participate in insurance billing, including Medicare, and payment is expected at the time of service. We advise you to ask your insurance company as to whether services from an out-of-network provider are covered. We do not guarantee reimbursement. Payments are accepted in cash, check or credit card (MC, Visa, and AMEX). Bounced checks are subject to an additional fee.
 5. **Some action steps will be required on your part.** Implementing what you learn and allowing yourself to think differently is the key to successful healing. For our work together to have the desired impact, you must be willing to make some lifestyle changes to

help yourself. You don't have to make all the changes overnight, but know that the sooner you make them, the faster you'll heal.

6. **Outside Office Hours Communication:** I absolutely invite you to relay your insights, breakthroughs, and treatment related questions to me between our scheduled appointment via our secure portal on my website! You will receive an invite to log you're your patient portal after your first visit with us. Please note any private health information is not secure when sent via regular email or text and that anything that requires more than a quick answer may be deferred to your next appointment with me. If you have questions or requests for the staff, you may email support@imacupuncture.com. We check this email during regular business office hours.

Please feel free to ask my staff if you have any questions about these policies. We thank you for your consideration and understanding. Thank you for honoring this! Now let's get started!
I have read and understood the above policies.

Patient Signature

Staff Signature

Date

___ Copy given to patient