Karen Kan, MD

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?

Health Problem:	You – when diagnosed?	Family Member – who?
Addictions (drug, alcohol etc.)		
Allergies (environmental)		
Arthritis		
Autoimmune Disease		
Cancer (what type?)		
Diabetes		
Digestive Problems		
Drug Addiction		
Eye Disease (e.g.Glaucoma)		
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

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

General:
- ☐ Fatigue
- ☐ Sleep Difficulty
  - Awakenings
  - Falling asleep
  - Lack of dreaming
  - Wake up tired
- ☐ Appetite Issues
- ☐ Feeling Stress
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Swelling anywhere on body

Eye, Ear, Nose, Throat
- ☐ Eye symptoms
- ☐ Stuffy or runny nose
- ☐ Seasonal allergies
- ☐ Sore Throat
- ☐ Hearing issues

Lung
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Coughing
- ☐ Mucus production

Heart
- ☐ Chest discomfort
- ☐ Palpitations/skipped beats
- ☐ Heart rhythm problems

Muscles/Joints
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Muscle spasms
- ☐ Muscle knots/trigger points
- ☐ Tightness/inflexibility
- ☐ Spine issues

Brain/Nervous System
- ☐ Headaches
- ☐ Dizziness
- ☐ Brain fog
- ☐ Memory Loss
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings/Irritability
- ☐ Nerve pain
- ☐ Tingling or Numbness

Reproductive Organs

Women:
- ☐ Vaginal itching or discharge
- ☐ Menstrual cramps
- ☐ Irregular periods
- ☐ Heavy periods +/- clots
- ☐ PMS
- ☐ Hot Flashes
- ☐ Vaginal dryness
- ☐ Painful sex
- ☐ Low libido
- ☐ Infertility
- ☐ Inability to lose weight
- ☐ Breast lumps or tenderness

Men:
- ☐ Low libido
- ☐ Hair loss
- ☐ Inability to lose weight

Urinary System
- ☐ Excessive urination
- ☐ Dark urine
- ☐ Narrow stream
- ☐ Prostate issues (men)
- ☐ Painful urination

Digestive System
- ☐ Constipation/hard stools
- ☐ Diarrhea/unformed stools
- ☐ Pale stool color
- ☐ Blood in stool
- ☐ Abdominal bloating
- ☐ Abdominal pain
- ☐ Undigested food in stool
- ☐ Heartburn
- ☐ Indigestion
- ☐ Excessive gas

Skin/Hair/Nails
- ☐ Rashes
- ☐ Acne
- ☐ Premature wrinkles
- ☐ Premature gray hair
- ☐ Hair Loss
- ☐ Brittle Nails
- ☐ "age" spots
- ☐ Moles/Warts
- ☐ Dry skin

Immune System
- ☐ Environmental allergies
- ☐ Food sensitivities
- ☐ Frequent colds/flus
- ☐ Swelling in legs
- ☐ Excessive immune reaction (or autoimmune)

OTHER:

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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:	☐ I'm mainly here for symptoms relief and am not interested in much else.	☐ 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.	☐ I'd like symptom relief, but am very interested in learning a holistic approach to *reversing* the aging/illness process.
How willing are you to make lifestyle changes to heal or reverse your illness?	☐ Mostly unwilling. I just want you to fix me.	☐ Somewhat willing depending on what you'll ask of me	☐ Very willing. I'll do whatever you suggest to get better!
How quickly are you usually able to adopt new instructions and habits?	☐ Pretty slow. Just give me one new thing to do at a time.	☐ Moderate – I'm able to adopt to 2 to 3 new things/habits at a time	☐ 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?	☐ I'd like to know if it doesn't cost too much. Mostly I want symptom relief.	☐ I'm somewhat interested in treating the cause rather than just the symptom.	☐ 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?	☐ I'm really looking for my health insurance to pay for most of it, so I can't invest much.	☐ 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.	☐ 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?	☐ Not that interested. I have too many emails to read. Sorry.	☐ Somewhat interested. Sign me up to the newsletter and I'll read and/or participate in what interests me.	☐ 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?	☐ I'm uncomfortable with prayer or discussion of God, Angels or spirits	☐ It's okay by me if it helps you be a more effective healer	☐ Extremely interested! The more help the better!

Patient/Parent Signature: _____ Date: _____

Doctor's Signature: _____

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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 Date
_____ ___ Copy given to patient
Staff Signature