# NEW PATIENT REGISTRATION INFORMATION

Date:_________________________ AcuSport Practitioner: _________________

Is today's visit because of a work injury?__________Auto Accident?_________Date of Injury: _________

## PERSONAL INFORMATION

Last Name:_________________________________First Name: ________________________________

Address: ______________________________________________________________________________

City:______________________________________State:_________________Zip: _________________

Home Ph:___________________________________Alt Ph: __________________________Cell/Work

E-mail: ______________________________________________Cell Phone Carrier __________________

Date of Birth:________________________________

Employer:__________________________________Occupation: ________________________________

Male:_________________ Female: _____________

Single:________Married:_________Divorced:_________Widowed:_________Domestic Partner:_______

Spouse:____________________________________Phone: ____________________________________

## RESPONSIBLE PARTY (Please complete if patient is under 18 years old)

Last Name:_________________________________First Name: ________________________________

Address: ______________________________________________________________________________

City:______________________________________State:_________________Zip: _________________

Home Ph:___________________________________Alt Ph: ____________________________________

Relationship to patient: ________________________________________________________________

## REFERRAL INFORMATION (Circle one and specify below)

Patient/Friend/Family Physician PCOM Web-site Yellow Pages Other

Name: _________________________________________________________________________________

## EMERGENCY CONTACT

Name:_____________________________________________Relationship: _________________________

Home Ph:__________________________________________Alt Ph: ______________________________

**Signature:__________________________________Date : _________________________**

## MEDICAL HISTORY

**1. How long ago did your symptoms start:**

________________________________________

________________________________________

**2. List and describe your symptoms in the order of importance:**

a.________________________________________

b.________________________________________

c.________________________________________

**3. List all activities that are limited because of your symptoms:**

________________________________________

________________________________________

**4. What are your goals in regards to your treatments:**

________________________________________

________________________________________

________________________________________

**Please indicate if you have a past history (circle all that apply):**

Headaches

High Blood Pressure

Bleeding Disorders

Heart Problems

Lung Problems

Hearing Problems

Ulcers

Reproductive Disorders

Psychiatric Problems

Frequent Infection/Illness

Bad Scarring

Street Drugs

Thyroid Problems

Circulatory Problems

Emotional Problems

Tested Positive for HIV

# Patient Pain Drawing

Name ______________________ Date ______________________

**Where is your pain now?**

- Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
- Mark the areas of radiation.
- Include all affected areas.
- To complete the picture, please draw in your face.

| Aching | Numbness | Pins and needles | Burning | Stabbing |
|---|---|---|---|---|
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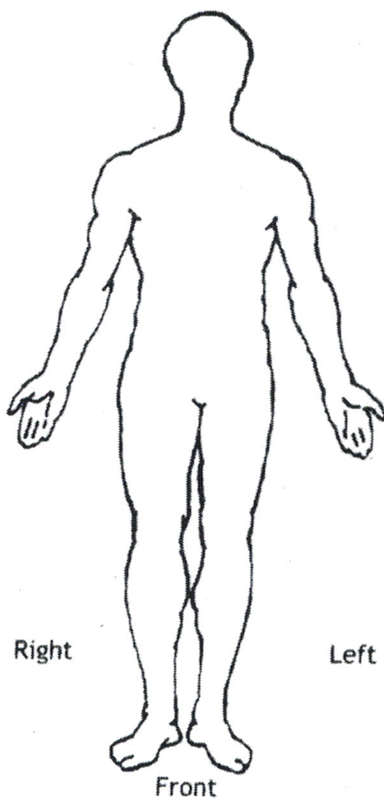


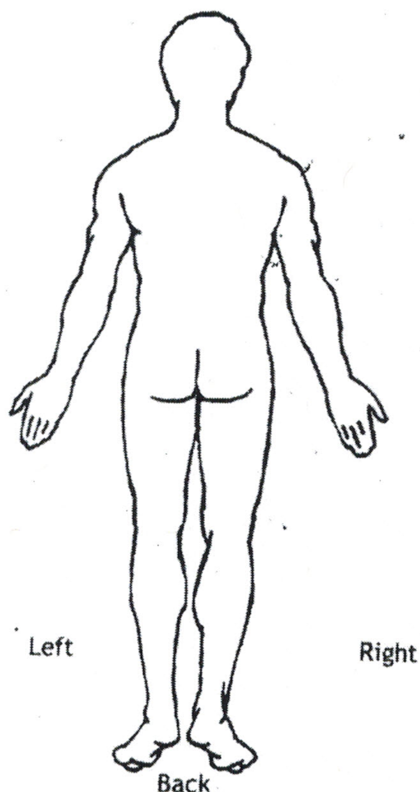


How bad is your pain right now?

No pain Worst pain

**CANCELATION POLICY:**

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

AcuSport Health Center has a 24 hour cancellation policy. You may cancel or change your appointment up to 24 hours before your treatment by calling (619).243.5109 or emailing us at AcuSport1804@gmail.com.
There will be a $25.00 fee for cancelations made within 24 hours, or for failure to make your scheduled appointment.

**I, ____________________________________________ understand that any change or cancellation of a scheduled appointment requires AT LEAST 24 hours' notice not to incur a $25.00 cancellation fee. I understand that if changes or cancellation to my appointment are not made prior to this timeframe or if I fail to show up for the scheduled appointment I will remain financially responsible for the payment in full prior to the next treatment.**

AcuSport Health Center
1804 Cable St. Suite B, San Diego, CA 92107
Phone: (619) 243-5109

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_______________________, have received a copy of AcuSport Health Center's Notice of Privacy Practices.

Printed Name: ____________________________________________________________

Signature: ________________________________________________________________

Date: ___________________