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: _____

Date of Birth: _____

Mobile Ph: _____ Alt Ph: _____

E-mail: _____

Employer: _____ Occupation: _____

Male: _____ Female: _____

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 Yelp Web-site Google 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:

_____

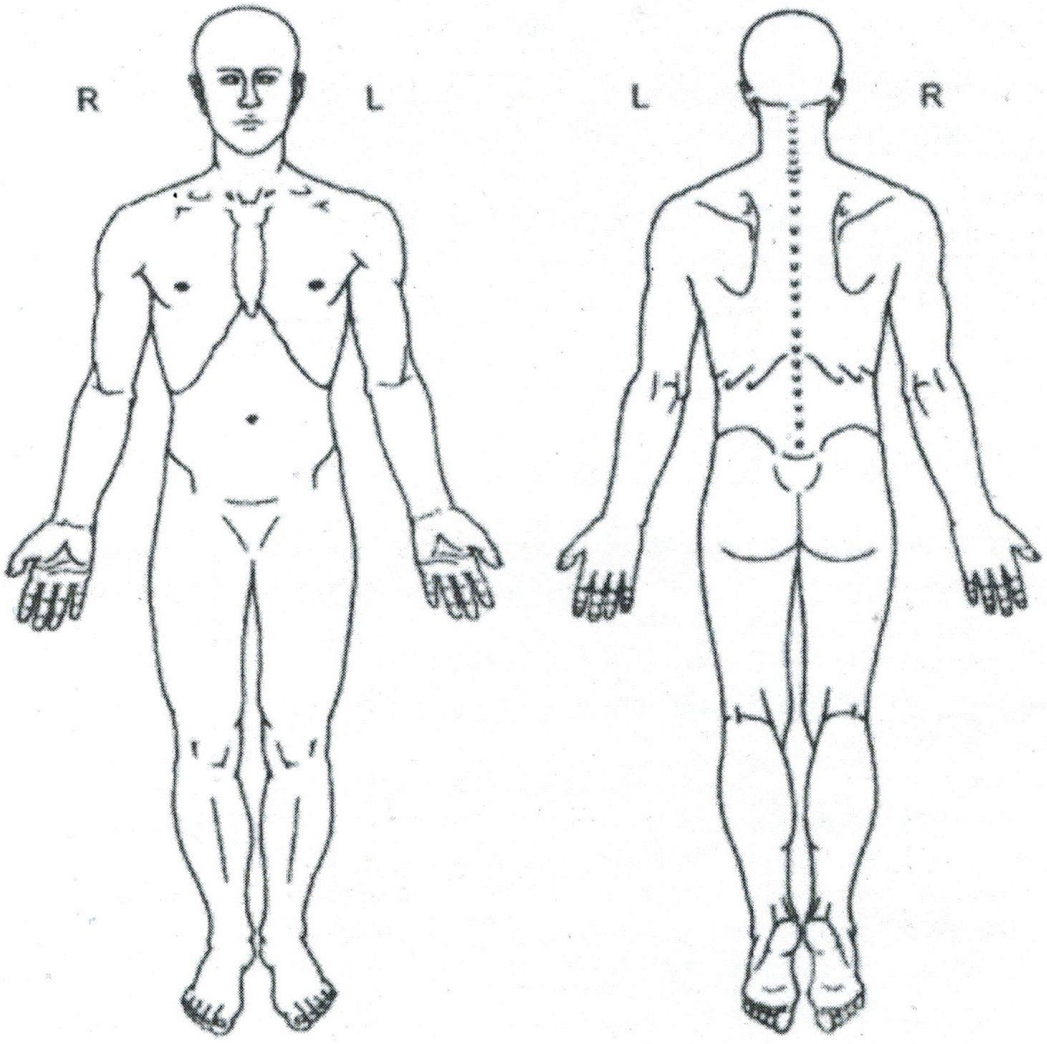
_____

_____

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		

CIRCLE THE AREAS EXPERIENCING PAIN



CANCELLATION 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 cancellations 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 cancellations 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: _____