Michigan Associates of
Acupuncture and
Integrative Medicine

Registration Form

Welcome to Michigan Associates of Acupuncture and Integrative Medicine

Please take a moment to provide us with some information about yourself and your health conditions so we may do our best to treat you.

Name_____

Home Phone #_____ Cell Phone #_____

Please indicate with a * which phone # you prefer us calling to confirm apts, etc...

Address_____

City_____State_____Zip_____

Sex : M F Age_____Birth Date_____

Occupation_____

Patient Employed by_____

Business Address_____

Business Phone Number_____

E-Mail Address _____

In case of an emergency, whom should we contact?

Name_____Phone #_____Relation_____

Whom may we thank for referring you?_____

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The treatment I am being given at Michigan Associates of Acupuncture and Integrative Medicine does not constitute a western medicine diagnosis. I understand that I am financially responsible for all charges. Furthermore, I understand that payment is due at the time of service and that cancellations made less than 24 hours will be charged the full rate for service.

Responsible Party **Date**

7001 Orchard Lake Road, Suite 120
West Bloomfield, MI 48322
248 | 737 | 7126

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Dr. Diana Quinn, Naturopathic Doctor

New Patient Intake Form

Name _____ Age _____
Date of Birth _____/_____/_____

Current health concerns - in order of priority Date of onset
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____

How do these conditions affect your life?
_____
_____
_____
_____

Medical History

Do you have a Primary Care Physician (PCP)? No Yes
Dr. _____ Phone_____
Do you wear a medic alert bracelet? No Yes, for _____
Have you consulted your PCP or another practitioner about the aforementioned condition(s)? No Yes If so, who?
_____
_____

Have you been to a Naturopathic Doctor before? No Yes
Dr. _____
Please state any previous diagnosis, treatment and results
_____
_____
_____
_____
_____

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Are you in a supportive relationship? ___ In a relationship you would like to change? ___

Do you ever feel unsafe in your own home? _____
Have you ever been physically, emotionally or sexually abused? (Y/N)

If you are experiencing physical, emotional or sexual harm from someone close to you, please talk to me so that I can help.

Please list any known allergies:
Drug_____

Environmental_____

Food_____

Other_____

Family History

Mother Health problems:
_____
Alive Deceased at age ____ Cause of death
_____
_____
Father Health problems:
_____
Alive Deceased at age ____ Cause of death_____

Please indicate any family members who have been affected by the following conditions and the age of onset:

Alzheimer's disease
_____
Alcoholism or substance
abuse_____

Allergies or Hay Fever_____

Asthma _____

Auto-immune disease_____

Cancer (specify type)_____

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Depression_____

Diabetes_____

Heart disease_____

High blood pressure_____

Obesity_____

Osteoporosis_____

Stroke_____

Thyroid problems_____

Other

_____

_____

_____

Medications

Please list any drugs/medications/supplements that you are taking or have taken in the last year. Use a separate page if necessary.

Medication	Reason for taking	Dosage	Dates taken

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