



ACADEMY FOR ACUPRESSURE AND ACUPUNCTURE (AAA)

Founder Director: Dr.H.Bhojraj BE (Hons) MD(Acu)

#2596, 11th Main, "E" Block, II Stage, Rajaji Nagar ,

Bangalore-560 010.Ph:080-23132103

Children's Immunity Development Programme

APPLICATION FORM

Name of the parent:			
• Profession and Qualification			
• Date of birth			
• Address			
• Phone Number	Land Line	Mobile	
Name of the spouse:			
• Profession and Qualification			
• Phone Number	Land Line	Mobile	
Name of the Child:			
• Date of birth			
• Height:	• Weight:		
• Eye Sight:			
• General Health of the child			
I agree to follow the preventive therapy taught by the research team and report back regularly for research records.			
I herewith enclose cash or Cheque for ` . 1000/- (Rupees one Thousand only) drawn in the name of Dr.H.Bhojraj a/c "Academy for acupressure and acupuncture" .			
Signature with date			



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Varicose Veins TreatmenT Camp

RegistRation FoRm

Name:

Phone:

Address:

Age/ Date of Birth:

Symptoms	Jan	Feb	Mar	Apr	May	Jun
Intensity of pain (scale of 0-10)						
Appearance of veins (spider or enlarged)						
Swelling of ankle						
Skin discoloration						
Skin ulcers near ankle						
Cramps						
Shrinking of skin						



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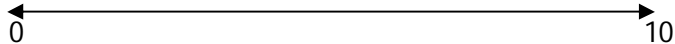
Knee Pain Treatment Camp

Registration Form

Name		Date of Birth	
Address			
Email :		Telephone / Mobile	

Please Answer all these questions

a.	How long you have been having knee pain?				
<input type="checkbox"/>	< 6 months	<input type="checkbox"/>	< 1 year	<input type="checkbox"/>	>1year
b.	Please describe the treatment undertaken so far?				
c.	Do you have osteoarthritis?				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
If Yes, please attach the diagnostic test details					
d.	Do you have rheumatoid?				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
If Yes, please attach the diagnostic test details					
e.	Are you on pain killers?				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
If Yes, give details on the medicines taken per day.					
f.	Is there any inflammation on the knee joint?				

	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, you can approximately give the measurement on the inflamed joint compared to normal joint.
g.	Do you get stiffness in the joint <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how long it lasts?
h.	Can you bend your knee backwards fully without pain <input type="checkbox"/> Yes <input type="checkbox"/> No If No, kindly state how much you can bend .
	<input type="checkbox"/> >30° <input type="checkbox"/> >60° <input type="checkbox"/> >90° <input type="checkbox"/> 180°
i.	How long can you walk now at a stretch
	<input type="checkbox"/> < 0.5 km <input type="checkbox"/> < 1 km <input type="checkbox"/> < 2 km
j.	Does walk increase your pain <input type="checkbox"/> Yes <input type="checkbox"/> No
k.	Have you taken any X-ray or MRI <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach the diagnostic details.
l.	What is your pain intensity now in a scale of 10 which represent the maximum knee pain you experinced 



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Back Pain Treatment Camp

Registration Form

Name		Date of Birth	
Address			
Email :		Telephone / Mobile	

Please answer all these questions

a.	How long you have been having back pain?		
	<input type="checkbox"/> < 6 months	<input type="checkbox"/> < 1 year	<input type="checkbox"/> >1year
b.	Please describe the treatment undertaken so far?		
c.	Do you have slipped disc.?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, please attach the diagnostic test details
d.	Do you have osteoarthritis?		

	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please attach the diagnostic test details
e.	Do you have rheumatoid? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please attach the diagnostic test details
f.	Are you on pain killers? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details on the medicines taken per day.
g.	Is there inflammation anywhere on the back of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, you can approximately mention the region viz neck, upper back, lower back, tail bone region etc.
h.	Do you get stiffness anywhere in the back of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how long it lasts?
i.	How long can you walk now at a stretch
	<input type="checkbox"/> < 0.5 km
j.	Does walk increase your pain <input type="checkbox"/> Yes <input type="checkbox"/> No
k.	Have you taken any X-ray or MRI <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach the diagnostic details.
l.	What is your pain intensity now in a scale of 10 which represent the maximum knee pain you experinced 