



**PHILADELPHIA**

**COMMUNITY ACUPUNCTURE**

50th Street and Baltimore Ave | Philadelphia PA 19143  
www.phillyacupuncture.com | (215) 729-2995

## Registration Form / Health History Questionnaire

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET      APT#      CITY      STATE      ZIP CODE

TELEPHONE \_\_\_\_\_  
HOME      WORK      CELL

EMAIL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

FEMALE / MALE / TRANSGENDER (FtM/MtF)

PREFERRED PRONOUN: M / F/ OTHER \_\_\_\_\_

HOW DID YOU LEARN ABOUT PCA? \_\_\_\_\_

FIRST TIME GETTING ACUPUNCTURE? \_\_\_\_\_

OCCUPATION \_\_\_\_\_ COMPANY NAME \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_  
HOME      WORK      CELL

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

### What are your primary reasons for coming in for treatment?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How is your sleep? \_\_\_\_\_

How is your digestion? \_\_\_\_\_

Medications/Supplements you take: \_\_\_\_\_

Major Illnesses/Accidents./Surgeries: \_\_\_\_\_

Do you have access to primary medical care? \_\_\_\_\_

Check those you have or have had this year:

- Difficulty coping with stress and/or emotions
- Depression/Anxiety
- Major life events (i.e. move, job loss, relationship change)
- Major change in overall health

Do you exercise regularly? \_\_\_\_\_

Do you want support in cutting back on any addictive habits? \_\_\_\_\_

For the following, please check YES for a condition you have currently and PAST for a condition you've had in the past, noting the date in the space provided.

**Skin:**

| <i>Currently Have?</i> | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|------------------------|--------------------------|--------------------------|--------------|
| Acne, Boils            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Acute Hair Loss        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Itching/Rash           | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other _____            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**Respiratory System:**

| <i>Currently Have?</i>   | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|--------------------------|--------------------------|--------------------------|--------------|
| Chronic Asthma           | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Chronic Cough            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Frequent Colds           | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Pain in Breathing        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Shortness of Breath      | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Sinus Congestion         | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Temporary Cough          | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Nasal Drainage to Throat | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other _____              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**Head, Ear, Eyes, Nose, Throat:**

| <i>Currently Have?</i> | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|------------------------|--------------------------|--------------------------|--------------|
| <b>Head:</b>           |                          |                          |              |
| Headaches              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Migraines              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Head Injury            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Hay Fever              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| <b>Ears:</b>           |                          |                          |              |
| Earaches               | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Ringing in Ears        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Impaired Hearing       | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Dizziness              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| <b>Eyes:</b>           |                          |                          |              |
| Eye Pain or Strain     | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Impaired Vision        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Tearing or Dryness     | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| <b>Nose:</b>           |                          |                          |              |
| Nose Bleeds            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Loss of Smell          | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| <b>Throat:</b>         |                          |                          |              |
| Goiter                 | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Hoarseness             | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Swollen Glands         | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Trouble Swallowing     | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Neck Pain/Stiffness    | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Frequent Sore Throat   | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other _____            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**Digestive System:**

| <i>Currently Have?</i> | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|------------------------|--------------------------|--------------------------|--------------|
| Nausea/vomiting        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Heartburn              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Gas or Bloating        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Internal Cramping      | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Constipation           | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Diarrhea               | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Loose Stool            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Hemorrhoids            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other _____            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**Cardiovascular:**

| <i>Currently Have?</i>     | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|----------------------------|--------------------------|--------------------------|--------------|
| Heart Disease              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Chest Pain                 | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Palpitations or Fluttering | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| High Blood Pressure        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Low Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Blood Clots                | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Ankle Swelling             | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Fainting                   | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other _____                | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**Urinary Tract:**

| <i>Currently Have?</i>                    | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|---|--------------------------|--------------------------|--------------|
| Frequent Infection                        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Frequent Urination                        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Inability to Hold Urine                   | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Burning or Pain or Blood During Urination | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Kidney Stones                             | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other _____                               | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**Musculoskeletal:**

| <i>Currently Have?</i>             | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|------------------------------------|--------------------------|--------------------------|--------------|
| Weakness                           | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Muscle Spasms or Cramps            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Joint Pain, Swelling, or Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Sciatica                           | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Fibromyalgia                       | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Broken Bones                       | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Any Other Pain                     | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Location: _____                    |                          |                          |              |
| Other _____                        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**Other:**

| <i>Currently Have?</i>      | <b>YES</b>               | <b>PAST</b>              | <b>When?</b> |
|-----------------------------|--------------------------|--------------------------|--------------|
| Thyroid/endocrine disorders | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Autoimmune disorders        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other _____                 |                          |                          |              |

**REPRODUCTIVE, IF APPLICABLE:**

| <i>Do you now, or have you ever had...?</i> |  | <b>When?</b> |
|---|--|--------------|
| Testicular Masses                           | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Testicular Pain                             | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Prostate Trouble                            | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Erection Difficulties                       | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Breast Lumps                                | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Nipple Discharge                            | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Fibroids or ovarian cysts                   | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Irregular Cycle                             | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| PMS Symptoms                                | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Painful Menses                              | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Clotting during menses                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Bleeding between periods                    | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Fertility difficulties                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Other _____                                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____        |
| Could you be pregnant?                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |              |

