



**PHILADELPHIA**

**COMMUNITY ACUPUNCTURE**

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

### Registration Form / Health History Questionnaire

LEGAL NAME \_\_\_\_\_

PREFERRED NAME OR NICKNAME \_\_\_\_\_

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

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

EMAIL \_\_\_\_\_

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

SEX: FEMALE / MALE / TRANSGENDER  
PREFERRED PRONOUN: M / F

WHERE OR FROM WHOM DID YOU LEARN ABOUT PCA? \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

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

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

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

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

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

**What are your primary concerns in coming for treatment?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ Current Weight \_\_\_\_\_ lb. Maximum Weight \_\_\_\_\_ lb. When? \_\_\_\_\_

**Allergies:**

Are you hypersensitive or allergic to:

Any Drugs?  Yes  No Please List:  
 \_\_\_\_\_  
 \_\_\_\_\_

Any Foods?  Yes  No Please List:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Medications:**

Please list any prescription medications, over the counter medications, vitamins, or other supplements you are currently taking:

\_\_\_\_\_  
 \_\_\_\_\_

**Symptom Profile:**

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

**Skin disorders:**

<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"/>	_____
Color Change	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema, Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nail Fungus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Respiratory System Disorders:**

<i>Currently Have?</i>	<b>YES</b>	<b>PAST</b>	<b>When?</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____

<i>Currently Have?</i>	<b>YES</b>	<b>PAST</b>	<b>When?</b>
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spitting Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Temporary Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nasal Drainage to Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Emotional or Mental Illness:**

<i>Currently Have?</i>	<b>YES</b>	<b>PAST</b>	<b>When?</b>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Considered or Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mood Swings	<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>			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Contacts or Glasses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Strain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tearing or Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spots in Front of Eyes	<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>Mouth:</b>			
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental Cavities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Thrush	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth Grinding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaw Problems, TMJ	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<b>YES</b>	<b>PAST</b>	<b>When?</b>
<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"/>	_____

<i>Currently Have?</i>	<b>YES</b>	<b>PAST</b>	<b>When?</b>
<b>Digestive System Disorders:</b>			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer	<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"/>	_____
Bowel Movement Frequency?	_____		

**Cardiovascular Disorders:**

Currently Have?	YES	PAST	When?
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<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"/>	_____
Phlebitis	<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 Disorders:**

Currently Have?	YES	PAST	When?
Frequent Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Night Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to Hold Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____

Currently Have?	YES	PAST	When?
Burning or Pain During Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased Frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Musculoskeletal Disorders:**

Currently Have?	YES	PAST	When?
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"/>	_____

**Miscellaneous:**

Currently Have?	YES	PAST	When?
Easy Bleeding or Bruising	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Slow Wound Healing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day Sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold Hands or Feet	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____

Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
- Type? _____			
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Lifestyle Habits:**

Do You....	No	Yes
Exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
What Kind? _____		
How Often? _____		
Take Vacations?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
How Often? _____		

**Sleep Habits:**

Do You....	No	Yes
Sleep Well?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Awaken Rested?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Average 6-8 Hours Sleep?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Spend Time Outside?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
What time of day is your energy at its best?		_____

**Tobacco, Food and Drink Habits:**

Do you...	No	Yes
Use Tobacco?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
How Much/How often? _____		
Smoked Previously?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
How Long? _____		
How many packs per day? _____		

Ever been treated for drug dependence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Drink Alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
How much? _____		
Drink Caffeinated Beverages?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
How often? _____		
Eat out often?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
How many times per week? _____		
How many meals do you eat per day? _____		
Go on diets often?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**Typical Food Intake:**

Breakfast _____	
Lunch _____	
Dinner _____	
Snacks _____	

**FOR MEN:**

<b>Do you now, or have you ever had...?</b>			<b>When?</b>
Testicular Masses	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Testicular Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Prostate Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Impotence	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Premature Ejaculation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Hernias	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Condyloma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Syphilis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Genital, Oral or Rectal Herpes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Gonorrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Other _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

**FOR WOMEN:**

<b>Do you now, or have you ever had...?</b>			<b>When?</b>
Breast Lumps	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Nipple Discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Breast Pain or Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Abnormal PAP Smear	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cervical Dysplasia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Vaginal Discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Gonorrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Syphilis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Genital, Oral or Rectal Herpes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Condyloma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Fibroids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Ovarian Cysts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Sexual Difficulties	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Are you sexually active?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Are you on birth control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Number of Pregnancies			_____
Number of Live Births			_____
Number of Miscarriages			_____
Number of Abortions			_____
Age at first menses			_____
Length of cycle in days			_____
Duration of period in days			_____
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	_____
Menopausal symptoms	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Other _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

\*\*\*\*\*

Is there any chance that you are now pregnant?  
 No     Yes \_\_\_\_\_

\*\*\*\*\*

**GENDER IDENTITY** *If applicable:*

Do you identify as Male, Female, Transgender, or other (please specify)? \_\_\_\_\_

Which pronoun do you prefer? M / F / Other \_\_\_\_\_

\*\*\*\*\*

**FOR EVERYONE:**

Is there anything else you would like your acupuncturist to know about your health history, your current health, or your intentions for being treated?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_