4001 Main Street, Suite #305
Philadelphia PA, 19127
(267) 417-0147
www.acupuncturerox.com

Registration Form / Health History Questionnaire

LEGAL NAME_________________________________ PREFERRED NAME_____________________________________

ADDRESS ____
STREET APT# CITY STATE ZIP CODE

TELEPHONE _________________________ ____
HOME WORK CELL

EMAIL ____

DATE OF BIRTH ____/_____/_______ FEMALE / MALE / TRANS (FTM/MTF) / INTERSEX
PREFERRED PRONOUN: M / F/ OTHER_________

HOW DID YOU LEARN ABOUT RCA? ____

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? __________

Could you be pregnant? ☐ No ☐ Yes

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?

____