NEW HAVEN COMMUNITY ACUPUNCTURE

Registration Form / Health History Questionnaire

1404 Whalley Avenue, Suite #1, New Haven, CT, 06515
www.NewHavenCommunityAcupuncture.com | 203.850.2395

Name _____

Address _____
No. Street Apt. City State Zip

Home _____ Work _____ Cell _____

E-Mail _____

DOB ____/____/____ Female / Male / Transgender (FtM/MtF)

Preferred Pronoun M / F / Other_____

How did you learn about NHCA ? _____

First time getting acupuncture ? _____

Occupation _____ Company Name _____

Emergency Contact _____ Relationship _____

Home _____ Work _____ Cell _____

Signature _____ Date ____/____/____

What are your primary reasons for coming in for treatments?

1. _____

2. _____

3. _____

How is your sleep?_____

_____

How is your digestion?_____

_____

Medications/Supplements you take _____

_____

_____

Major Illnesses/Accidents/Surgeries _____

_____

Do you have access to a primary care physician _____

Check those you have or have had this year:

- ☐ Difficulty coping with stress/emotions
- ☐ Depression/Anxiety
- ☐ Major life changes (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? _____

_____

Skin:	YES	PAST	When?
Acne, Boils	☐	☐	_____
Acute Hair Loss	☐	☐	_____
Itching/Rash	☐	☐	_____
Other_____	☐	☐	_____

Respiratory:	YES	PAST	When?
Chronic Asthma	☐	☐	_____
Chronic Cough	☐	☐	_____
Frequent Colds	☐	☐	_____
Pain in Breathing	☐	☐	_____
Shortness of breath	☐	☐	_____
Sinus Congestion	☐	☐	_____
Temporary Cough	☐	☐	_____
Nasal Drainage to Throat	☐	☐	_____
Other_____	☐	☐	_____

Head:	YES	PAST	When?
Headaches	☐	☐	_____
Migraines	☐	☐	_____
Head Injury	☐	☐	_____
Hay Fever	☐	☐	_____
Ears:			
Earaches	☐	☐	_____
Ringing in Ears	☐	☐	_____
Impaired Hearing	☐	☐	_____
Dizziness/Vertigo	☐	☐	_____
Nose:			
Nose Bleeds	☐	☐	_____
Loss of Smell	☐	☐	_____

Throat:	YES	PAST	When?
Goiter	☐	☐	_____
Hoarseness	☐	☐	_____
Swollen Glands	☐	☐	_____
Trouble Swallowing	☐	☐	_____
Neck Pain/Stiffness	☐	☐	_____
Frequent Sore Throat	☐	☐	_____
Other_____	☐	☐	_____

Digestive System:	YES	PAST	When?
Nausea/Vomiting	☐	☐	_____
Heartburn	☐	☐	_____
Gas or Bloating	☐	☐	_____
Internal Cramping	☐	☐	_____
Constipation	☐	☐	_____
Diarrhea	☐	☐	_____
Loose Stool	☐	☐	_____
Hemorrhoids	☐	☐	_____
Other_____	☐	☐	_____

Cardiovascular:	YES	PAST	When?
Heart Disease	☐	☐	_____
Chest Pain	☐	☐	_____
Palpitations	☐	☐	_____
High Blood Pressure	☐	☐	_____
Low Blood Pressure	☐	☐	_____
Blood Clots	☐	☐	_____
Ankle Swelling	☐	☐	_____
Fainting	☐	☐	_____
Other_____	☐	☐	_____

Urinary:	YES	PAST	When?
Frequent Infection	☐	☐	_____
Frequent Urination	☐	☐	_____
Inability to Hold Urine	☐	☐	_____
Burning/Pain	☐	☐	_____
Blood in Urine	☐	☐	_____
Kidney Stones	☐	☐	_____
Other_____	☐	☐	_____

Musculoskeletal:	YES	PAST	When?
Weakness	☐	☐	_____
Muscle Spasms	☐	☐	_____
Muscle Cramps	☐	☐	_____
Joint Pain, Swelling	☐	☐	_____
Stiffness	☐	☐	_____
Sciatica	☐	☐	_____
Fibromyalgia	☐	☐	_____
Broken Bones	☐	☐	_____
Any other Pain_____			
Other_____	☐	☐	_____

Other:	YES	PAST	When?
Thyroid/endocrine	☐	☐	_____
Diabetes	☐	☐	_____
Autoimmune Disorder	☐	☐	_____
Testicular Masses	☐	☐	_____
Testicular Pain	☐	☐	_____
Prostrate Trouble	☐	☐	_____
Erection Difficulties	☐	☐	_____
Breast Lumps	☐	☐	_____
Nipple Discharge	☐	☐	_____
Fibroids/Ovarian Cysts	☐	☐	_____
Irregular Cycle	☐	☐	_____
PMS Symptoms	☐	☐	_____
Painful Menses	☐	☐	_____
Clotting w/Menses	☐	☐	_____
Bleeding between periods	☐	☐	_____
Fertility difficulties	☐	☐	_____
Other_____			_____
Could you be pregnant?	☐	☐	