



Chester County Herbs & Acupuncture

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West Chester, PA 19380

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Registration Form

All Information is CONFIDENTIAL

Date _____

Name: _____ Date of Birth: _____
(Last) (First)

Address: _____

(City) (State) (Zip Code)

Occupation: _____

Phone numbers: Home _____
Cell _____
Work _____
e-mail _____

Emergency contact: Name _____ Phone# _____

How were you referred to this practice?

Physician: _____ Phone # _____

Address: _____

Medical History Form

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Name: _____

Describe the reason for your visit?

Have you worked with other professional for this problem?
Who?

Have you had medical tests for this condition?

If so, what tests have been done?

What was the out come?

History:

1. Childhood Illnesses (Include age)

2. Adult Illnesses (Include age)

Do you have Allergies: Medicine, Food, Other. Briefly describe Reaction.

What Medications/Supplements/Herbs do you take or have you taken? (Include dosage and date Started)

What Surgeries have you had? (Include Dates)

Do you have Pain?

Where do you have pain?

On a scale of 1-10 least to worst what is your level of pain 1 2 3 4 5 6 7 8 9 10

What makes it better or worse?

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How is your energy 1 2 3 4 5 6 7 8 9 10

Name: _____

How is your Sleep?

Do you fall asleep easily?

Do you sleep soundly through the night?

Do you have night sweats or have to wake to urinate?

Do you snore?

How is your Appetite? Do you get hungry?

What do you get hungry for?

How many times per day do you eat?

Foods avoided or not tolerated.

How is your digestion? Do you have bloating, gas or heartburn?

Elimination:

How often do you urinate?

Is your urine cloudy, dark, clear, painful, urgent or dribbling?

How often do you have bowel movements?

Are your stools formed, loose, hard to pass, dark, bloody, pale, painful, or do you have diarrhea?

Thirst: Are you thirsty frequently?

How much do you drink?

Skin : Do you have dryness, cracking, rashes, pimples or sensitivities with your skin? If so where?

Temperature: Do you tend to be more hot or cold?

Do you crave hot or cold food or drink?

Respiration: Do you have any breathing difficulty?
When?

Hard to inhale or exhale?

Do you get congested?

Name: _____

How often do you or did you have menstrual periods?

How long do or did your periods last?

Are your periods painful?

Do you have premenstrual discomfort?

When was the first day of your last period?

Have you been or are you pregnant?

How is your emotional balance? Do you find that you have a variety of emotions appropriate to the circumstance or do you tend to be stuck in fear, sadness, obsessive thinking, addictive behaviors, or are you always happy?

Life Style: Do you exercise? What kind? How often?

Do you drink alcoholic beverages? How much?

Do you use tobacco products/ How often? How much?

Any other problems or concerns not listed please do so below or please discuss with the Practitioner:

I _____ attest that the above information is complete and accurate. If there are any changes to the above I will inform my practitioner at this office.

Patient Signature _____ Date _____