Confidential Patient Health Record **Date:**

Note: Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Personal Health History						
Name:				Home Phone:		
Address:				Cell Phone:		
City:				Business Phone:		
Province:		Postal Code:		E-mail:		
Date of Birth:	M	D	Y	Age:	Sex:	Weight:
Circle One: *Single Married Widowed Divorced*				Spouse's Name:		
Names and Ages of Children:						
Employer:				Type of Work:		
Emergency Contact:				Emergency Contact Number:		
Who may we thank for your referral? (How did you hear about us?)						
☐ Yes, I would like to receive emails, including insurance receipts from CLINIC ☐ No emails ever.						

Is this your first experience with acupuncture or Chinese Medicine?		☐ Yes ☐ No
(Women only)	Are you currently pregnant?	☐ Yes ☐ No
	Are you presently trying to get pregnant?	☐ Yes ☐ No

What do want treated with acupuncture? *(primary complaint, symptom)*
How long have you had this condition? Onset: ☐ Sudden ☐ Gradual
How often do you have this symptom?
What medical diagnosis have you received for this condition?
Symptoms relieved by:
Symptoms worsened by:
What other treatments have you received for this condition?
What prescription or over-the-counter medications are you taking?

Family Medical History

Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis, etc.

Father:	Mother:
Siblings:	Grandparents:

Past Medical History

☐ HIV	☐ Fibromyalgia	☐ Multiple Sclerosis
☐ Tuberculosis	☐ Heart Disease	☐ Polio
☐ Hepatitis A/B/C	☐ Pacemaker	☐ Sinus Infections
☐ Asthma	☐ Rheumatic Fever	☐ Alcoholism
☐ Emphysema	☐ Scarlet Fever	☐ Drug Addictions
☐ Diabetes	☐ Herpes/STD	☐ Allergies: _____
☐ Epilepsy/Seizures	☐ Joint Replacements	_____
☐ Anemia	☐ Arthritis	☐ Cancer: _____
☐ Hypothyroid	☐ Mumps/Measles/Chicken Pox	☐ Surgeries: _____
☐ Hyperthyroid	☐ Whooping Cough	_____

Exercise & Energy

How is your energy?	☐ Exhausted ☐ Low ☐ Below Normal for me ☐ Average ☐ Good/High
What time of day is your energy: Highest?	☐ Mornings ☐ Noon ☐ Afternoon ☐ Early Evening ☐ Evening/Night
What time of day is your energy: Lowest?	☐ Mornings ☐ Noon ☐ Afternoon ☐ Early Evening ☐ Evening/Night
Do you fatigue easily?	☐ Yes ☐ No
How often do you exercise?	☐ 4-7/week ☐ 2-3/week ☐ 1/week ☐ 1-4/month ☐ Rarely/never
What kind of exercise do you do regularly?	

Emotions & Sleep

How do you feel emotionally?			
How do you hold/handle your stress?			
How do you feel generally about your work and home life?			
How long do you normally sleep?	☐ Less than 4 hrs ☐ 4-6 hrs ☐ 6-7 hrs ☐ 7-9 hrs ☐ 9 hrs or more		
Do you have: (check all that apply)			
☐ Panic attacks	☐ Depression	☐ Anxiety	☐ Irritability
☐ Bad temper	☐ Mood Swings	☐ Poor memory	☐ Difficult concentration
Do you have difficulties with: (check all that apply)			
☐ Falling asleep	☐ Staying asleep	☐ Dream-disturbed sleep	☐ Nightmares
☐ Waking up at night	☐ Waking up multiple times	☐ Can't fall back asleep	☐ Wake up not rested

Gastrointestinal Symptoms

Do you have: (check all that apply)			
☐ Belching	☐ Nausea	☐ Vomiting	☐ Vomiting of blood
☐ Ulcers	☐ Bloating	☐ Heartburn/acid reflux	☐ Crohn's/Celiac Disease
☐ Hernia	☐ Indigestion	☐ Severe Abdominal pain	☐ IBS/Colitis/Diverticulitis

Bowel Movements

How often do you have a bowel movement?	/ day	or	/ week
Do you have: (check all that apply)			
☐ Constipation	☐ Diarrhea	☐ Gas	☐ Irregular bowel movements
☐ Burning sensation	☐ Hemorrhoids	☐ Itchiness after BM	☐ Undigested food in stool
☐ Loose stools	☐ Hard stools	☐ Blood in stool	☐ Painful bowel movements
☐ Very smelly stools	☐ White mucus in stools	☐ Abdominal cramping	☐ Intestinal sounds

Urinary Symptoms

How often do you urinate?	/ day		
Quality/Colour of Urine:	☐ Pale yellow	☐ Dark yellow/orange	☐ Bubbles ☐ Cloudy
Do you have: (check all that apply)			
☐ Trouble starting stream	☐ Frequent urination	☐ Blood in urine	☐ Urinary tract infections
☐ Pain urinating	☐ Burning	☐ Dribbling urine	☐ White/yellow mucus in urine
☐ Kidney stones	☐ Occasional Incontinence	☐ Incontinence	☐ Kidney disease

Muscles, Joints & Bones

Do you have: (check all that apply)

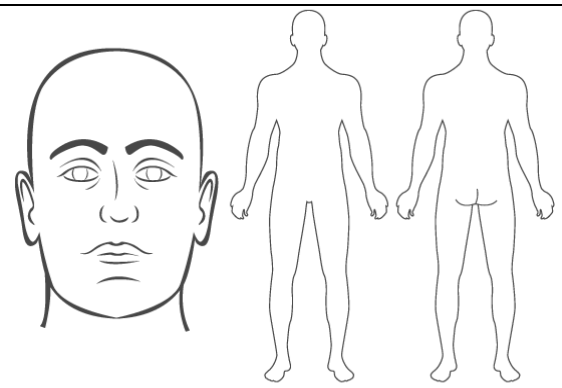
☐ Swollen joints ☐ Muscle pain ☐ Tendonitis
☐ Stiff joints ☐ Muscle tension ☐ Fibromyalgia
☐ Bone pain ☐ Muscle cramps ☐ Repetitive Strain Injury
☐ Arthritis/Joint pain ☐ Restless Leg Syndrome ☐ Fractured Bone:_____

Describe the pain/tension: (check all that apply)

☐ Sharp ☐ Dull ☐ Superficial ☐ Deep
☐ Numbness ☐ Tingling ☐ Burning ☐ Squeezing
☐ Aching ☐ Stabbing ☐ Shooting

Applying heat make the symptom: ☐ Better ☐ Worse ☐ No difference
Applying cold/ice makes the symptom: ☐ Better ☐ Worse ☐ No difference
Applying pressure makes the symptom: ☐ Better ☐ Worse ☐ No difference

Please mark on the diagram where you feel symptoms like pain, numbness, tension, stiffness, tenderness, tightness, etc:



Eyes, Ears, Nose, Throat, & Head

Do you have: (check all that apply)

☐ Frequent colds/flu ☐ Chronic runny nose ☐ Frequent sore throat
☐ Chronic cough ☐ Coughing blood ☐ Cough up mucous
☐ Pain on inhaling ☐ Asthma ☐ Nose bleeds
☐ Painful/red eyes ☐ Poor vision ☐ Spots/floaters
☐ Dizziness ☐ Cold sores ☐ Bleeding gums
☐ Dry mouth ☐ Ear pain ☐ Ringing in ears
☐ Clogged/popping in ears ☐ Jaw/TMJ pain
☐ Headaches ☐ Migraines:

Where? ☐ Front/forehead ☐ Top of head ☐ Sides/Temples ☐ Back/occipital/neck ☐ Behind eye(s)
How often do you get a headache? ☐ 1-2/year ☐ 3-11/year ☐ 1/month ☐ 2-4/month ☐ 1-2/week ☐ More than 2/week
How long does a bad headache last without medication? ☐ Minutes ☐ 1-4 Hours ☐ 4-12 hours ☐ 12-24 hours ☐ 2+ Days

Do you smoke? ☐ Yes ☐ No ☐ I used to
How many cigarettes/day now? _____
How many years? _____
Do you want to quit smoking? ☐ Yes ☐ No
When did you start? (age/year) _____
When did you quit? (age/year) _____

Skin & Hair

Do you have: (check all that apply)

☐ Dry skin ☐ Skin rashes ☐ Itching ☐ Bruise easily
☐ Eczema ☐ Hives ☐ Hair loss ☐ Premature greying
☐ Oily skin ☐ Facial pimples ☐ Facial acne ☐ Body acne

Heart & Lungs

Do you have: (check all that apply)

☐ Chest/lung pain ☐ Palpitations ☐ Irregular heart beat
☐ Asthma ☐ Cold hands and feet ☐ Hypertension
☐ Emphysema/COPD ☐ Ankle/leg swelling ☐ Hypotension
☐ Previous Heart attack #_____ ☐ Shortness of breath on exertion ☐ Varicose veins

☐ Angina/Heart disease ☐ Shortness of breath at rest ☐ Poor circulation

Temperature/Sensation

Do you have: (check all that apply)

☐ Feel cold all the time	☐ Feel cold often	☐ Cold feet or hands	☐ Dislike dry air
☐ Feel hot all the time	☐ Feel hot often	☐ Hot feet or hands at night	☐ Dislike humidity
☐ Feel better in cold weather	☐ Feel better in hot weather	☐ Feel better in dry weather	☐ Feel better in humid weather
☐ Feel worse in cold weather	☐ Feel worse in hot weather	☐ Feel worse in dry weather	☐ Feel worse in humid weather
☐ Feel worse in winter	☐ Feel worse in summer	☐ Feel worse in spring	☐ Feel worse in autumn
☐ Dislike wind			

Men Only

Do you have: (check all that apply)

☐ Prostate issue	☐ Erectile dysfunction	☐ Infertility problem	☐ Testicular/Prostate Cancer
☐ Night sweats	☐ Profuse sweating	☐ Other cancer	☐ Mood swings/angry outbursts
☐ Loss of morning erection			

Women Only

Do you have: (check all that apply)

☐ Menstrual cramps/pain	☐ Late/missed periods	☐ Early/frequent periods	☐ Mid-cycle spotting
☐ PCOS/Ovarian Cysts	☐ Vaginal itching/discharge	☐ PMS symptoms	☐ PMS/Menopause headaches
☐ Uterine fibroids	☐ Vaginal dryness	☐ Day sweats	☐ Breast problem
☐ Menopausal symptoms	☐ Hot flashes	☐ Night sweats	☐ Breast cancer
☐ Hysterectomy	☐ Endometriosis	☐ Recurrent yeast infection	☐ Ovarian/Cervical/Uterine cancer
☐ Tender breasts	☐ Fibrocystic breasts	☐ Pain during sex	

Reproductive history:

Menstruation started at age: _____ Menstruation ended at age: _____

☐ Children # _____ ☐ Pregnancies # _____ ☐ Abortions # _____ ☐ Miscarriages # _____

Menstruation: (check all that apply)

Blood colours: ☐ bright red ☐ dark red ☐ pale/pink ☐ blackish ☐ purple ☐ brown

Clot: ☐ no clots ☐ some small clots ☐ some large clots ☐ dark clots ☐ red clots ☐ dilute/watery

Flow: ☐ heavy ☐ very heavy ☐ very light ☐ light

Days of flow: ☐ none ☐ 1-3 days ☐ 4-6 days ☐ 7 or more days

Menstrual Pain: ☐ before flow ☐ first day ☐ during period, any day ☐ after period ☐ on ovulation (two weeks)

Fertility:

☐ I am trying to conceive ☐ I am not trying to get pregnant, but could become pregnant during the course of treatments.

Please tell me what you have done in the past and what you are doing currently to try to conceive a child:

Please provide any hormone or other fertility test results, if known:

Current Health Professionals

I am currently seeing: (check all that apply)		
☐ Family Medical Doctor	Name:	Clinic:
☐ Chiropractor	Name:	Clinic:
☐ Massage Therapist	Name:	Clinic:
☐ Physiotherapist	Name:	Clinic:
☐ Naturopathic Doctor	Name:	Clinic:
☐ Dentist	Name:	Clinic:
☐ Acupuncturist	Name:	Clinic:
☐ Personal Trainer	Name:	Gym:
☐ Other: _____	Name:	Clinic:

Previous Health Professionals

Previously, I have been treated by: (check all that apply)	How long did you receive treatment?			Helped Symptoms	Some Difference	No Help or Change
☐ Acupuncturist	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Chiropractor	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Massage Therapist	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Physiotherapist	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Naturopathic Doctor	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Nutritionist/Dietician	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Other: _____	☐ Weeks	☐ Months	☐ Years	☐	☐	☐