New Patient Health History

Please fill out this form to help us focus on your unique history and symptoms and patterns. All answers are confidential. If you have any questions, please ask.

Date: _____

Name: _____ **Address:** _____

City: _____**Province:** _____**Postal Code:** _____

Home Ph: _____**Business Ph:** _____**Email address:** _____

Sex: ☐ M ☐ F Birth: dd/mm/yy_____/_____/_____ **Age:** _____ **height:** _____ **weight:** _____

Bus. Employer/Occupation: _____ **Type of Work:** _____ **Marital Status:** _____

Spouse's Name: _____ **Children's Name:** _____

Alberta Health Care Number: _____**S.I.N.** _____

If we need to contact you, messages can be left as (check all that apply): ☐ work ☐ home ☐ e-mail
Would you like to receive our clinic newsletter via e-mail? (yes/no)

How did you hear about our clinic? _____ **Referred to this office by:** _____

Emergency Contact (if different): _____ **Phone:** _____

Your Current Health Concerns

What is your **main** reason for coming in today? If you have a specific health condition, please describe in detail. When was the very first time you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation?

Are you pregnant? ☐ **Yes** ☐ **No** **Prone to fainting?** ☐ **Yes** ☐ **No** **Have you eaten today?** ☐ **Yes** ☐ **No**

Have you had acupuncture before? ☐ **Yes** ☐ **No** **Chinese Herbals?** ☐ **Yes** ☐ **No**

Names of other health care providers:
Assisting at this time

Medical Doctor: _____
Naturopath Dr.: _____
Chiropractor: _____
Physiotherapist: _____
Massage Therapist _____

Main Reason for Today's Visit:
_____

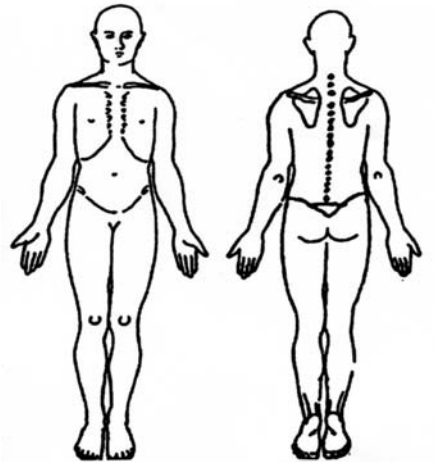
Do you have a medical diagnosis? ☐ **Yes** ☐ **No** **if yes :** _____

When did this first begin? _____

Were there any related circumstances: emotional, physical or mental stress? Or were you ill when this began?
_____
_____

MUSCULO-SKELETAL PAIN

☐	**Neck/shoulder pain**	☐	**Nerve-like pain**
☐	**Muscle pain**	☐	**Hip Pain**
☐	**Limited use**	☐	**Elbow Pain**
☐	**Numbness**	☐	**Tingling**
☐	**Rib pain**	☐	**Knee Pain**
☐	**Carpal Tunnel**	☐	**Plantars Fasicitis**
☐	**Upper Back pain**	☐	**Joint pain**
☐	**Low Back pain**	☐	**Limited range of motion**
☐	**Dull aching pain**	☐	**Sharp/shooting pain**



What makes it better? _____

What makes it worse? _____

Surgeries (ie. Appendix, Gall Bladder, Hysterectomy etc.): _____

_____

Traumas (Auto, accidents, falls): _____

_____

Major Allergies (Drugs, Chemicals, Foods): _____

_____

YOUR PERSONAL HEALTH HISTORY (Please check)

Now	Past		Now	Past		Now	Past	
☐	☐	**Anemia**	☐	☐	**Hayfever/Allergies**	☐	☐	**Mononucleosis**
☐	☐	**Arthritis**	☐	☐	**Head Injury**	☐	☐	**Osteoporosis**
☐	☐	**Asthma**	☐	☐	**Hepatitis A B C**	☐	☐	**Peptic Ulcer**
☐	☐	**Cancer**	☐	☐	**Herpes**	☐	☐	**Prostate Trouble**
☐	☐	**Candida**	☐	☐	**Heart Disease**	☐	☐	**Skin Disorder**
☐	☐	**Depression**	☐	☐	**High Blood Pressure**	☐	☐	**Low Blood Pressure**
☐	☐	**Diabetes Headaches**	☐	☐	**Epilepsy/Seizures**	☐	☐	**Stroke**
☐	☐	**Edema**	☐	☐	**Immunosuppression**	☐	☐	**TB**
☐	☐	**Gall stones**	☐	☐	**Kidney Stones**	☐	☐	**Thyroid Disease**

Personal &/or Occupational Stress:

_____

_____

_____

(Chemical, physical, psychological)

MEDICATIONS:

☐	**Tylenol**	☐	**Ibuprofen**	☐	**Pain Medication**
☐	**Cortisone**	☐	**Steroids**	☐	**Antibiotics**
☐	**Antidepressants**	☐	**Antacids/Tagamet**		
☐	**Anti anxiety**	☐	**Cholesterol**	☐	**Blood Pressure**

EXERCISE PROGRAM

Weights ☐ **Cardio** ☐ **Yoga/Pilates** ☐
Walking ☐ **Cycling** ☐ **Running** ☐
Other: _____

SUPPLEMENTS (vitamins):

_____

_____

_____

DIET/THIRST:

APPETITE ☐ **Poor** ☐ **Low** ☐ **Heavy** ☐ **Normal** ☐ **Changed**

Approximately How many times per week do you eat?

_____**Regular Meals?** _____**Red Meat** _____**Poultry** _____**Fish**
_____**Game** _____**Breads** _____**rice/Grains** _____**pasta**
_____**Vegetables(raw)** _____**Vegetables(cooked)** _____**Beans/Legumes** _____**Sweets** _____**Salty**

THIRST Do you prefer your drinks: ☐ **ice cold** ☐ **hot** ☐ **room temperature**

# of glasses consumed daily? _____**water** _____**coffee/tea** _____**Pop** _____**Juice** _____**Milk**
Do you have??
☐ **Normal thirst** ☐ **Thirsty all the time** ☐ **Thirst with no desire to drink** ☐ **Never thirsty**

HABITS: daily intake?

_____**Coffee** _____**Alcohol** _____**Cigarettes** _____ **Other**_____

FAMILY HEALTH STATUS: (parents/siblings etc.)

☐ Cancer ☐ Diabetes ☐ Asthma ☐ High Blood Pressure
☐ Seizures ☐ TB ☐ Ulcer ☐ Asthma
☐ Depression ☐ Heart Disease ☐ Stroke ☐ Hepatitis
☐ Kidney Disease ☐ Cholesterol ☐ Liver Disease

GENERAL: (Energy, Sleep, Body Temperature)

☐ Good Energy ☐ Fatigue ☐ Fatigued easily ☐ Sudden energy drop?(time)_____
☐ Tired upon waking ☐ Light Sleep ☐ Lack of strength ☐ Dream-disturbed sleep
☐ Poor Sleep ☐ Heavy Sleep ☐ Sleep interrupted by pain ☐ Rested upon waking

How many hours of sleep do you need to feel rested?_____ Dizziness Vertigo

☐ Chills ☐ Fever ☐ Night Sweats ☐ Sweat easily
☐ Cold hands or feet ☐ Poor circulation ☐ Sweat easily on exertion
☐ Normal perspiration ☐ Low grade fever? Time of day_____
☐ Recent weight loss/gain ☐ Bleed or bruise easily

HEAD, EYES, EARS, NOSE , THROAT

☐ Eye pain ☐ Blurry vision ☐ Eye strain ☐ Red itch eyes ☐ Dry eyes
☐ Night Blindness ☐ floaters ☐ Hearing loss ☐ Ringing in ears ☐ ear aches
☐ Sinus problems ☐ Excessive phlegm ☐ Lump in throat ☐ Nose bleeds ☐ Facial Pain
☐ Repeated sore throat ☐ Trigem. Neuralgia ☐ TMJ ☐ Teeth problems ☐ Teeth Grinding

HEADACHES

☐ Distending ☐ Pricking ☐ Heavy ☐ Burning ☐ Forehead ☐ Occipital
☐ Temporal ☐ Meniere's ☐ top of head ☐ Difficulty with light / sound ☐ Migraines

SKIN & HAIR

☐ Rashes ☐ Hives ☐ Eczema ☐ Psoriasis ☐ Vitilago
☐ Dermatitis ☐ Loss of Hair ☐ Unusual/Early Greying ☐ Dandruff ☐ Acne

RESPIRATORY & CARDIOVASCULAR

☐ Difficulty Breathing on lying ☐ Bronchitis ☐ Chest Tightness ☐ Phlegm production
☐ Chest Fullness ☐ Chronic cough ☐ Pain on coughing ☐ Coughing Blood
☐ Shortness of Breath ☐ Wheezing ☐ Lack of smell ☐ Chest Pain
☐ High Blood Pressure ☐ Low Blood Pressure ☐ Laboured breathing
☐ Blood Clots ☐ Heart Palpitations ☐ tachycardia ☐ Irregular Heartbeat

GASTROINTESTINAL

☐ Indigestion ☐ Gas ☐ Bloating ☐ Nausea ☐ Vomiting
☐ Bad Breath ☐ Constipation ☐ Belching ☐ Loose stools ☐ diarrhea
☐ Hemorrhoid ☐ Dry Stool ☐ Heart burn ☐ Undigested Food ☐ Oral Canker sores
☐ Abdominal Cramps/Pain # of Bowel movements daily_____ ☐ chronic laxative use
☐ Blood in stool

GENITO-URINARY

☐ **Normal amount**	☐ **Frequent urination**	☐ **Decrease in flow**	☐ **Increase in flow**
☐ **Blood in Urine**	☐ **Kidney Stones**	☐ **Incontinence**	☐ **Dribbling**
☐ **Pain on urination**	☐ **Urgency**	☐ **Burning**	
Colour:	☐ **Normal**	☐ **Dark**	☐ **Unusually clear** ☐ **Odourous**

NEUROPSYCHOLOGICAL

☐ **Loss of Balance**	☐ **Anxiety**	☐ **Depression**	☐ **Seizures**	☐ **Concussion**
☐ **Irritability**	☐ **Poor Memory**	☐ **Concentration**	☐ **Easily stressed**	☐ **Bad temper**
☐ **Tics/twitching**	☐ **Mood Swings**	☐ **Lack of Coordination**	☐ **Area of numbness**	

Do you experience excessive:____Anger ____Fear ____Sadness ____Anxiety ____Depression

MEN ONLY:

☐ **Impotence**	☐ **Infertility**	☐ **Decreased Libido**	☐ **Increased Libido**
☐ **Spermatorrhea**	☐ **Vasectomy**	☐ **Inhibited orgasm**	☐ **Prolonged sexual dysfunction**
☐ **Premature Ejaculation**		☐ **Erection not sustained**	☐ **Nocturnal Emissions**

WOMEN ONLY

☐ **Age of first menses**	☐ **Unusual menses**	☐ **Irregular Periods**	☐ **PMS**	☐ **Normal cycle**
☐ **Duration of cycle**	☐ **Heavy**	☐ **Light**	☐ **Vaginal discharge**	☐ **Clots**
☐ **Painful periods**	☐ **Back Pain**	☐ **Headaches**	☐ **Middleschmerz(pain @ ovulation)**	
☐ **Days between menses**	☐ **Breast Tenderness**	☐ **Breast lumps**	☐ **Ovarian cysts**	☐ **Cramps**
☐ **Spotting**	☐ **Lack of menses**	☐ **Flooding**	☐ **Water Retention**	
☐ **Endometriosus**	☐ **Uterine Fibroids**	☐ **Bladder Infections**	☐ **Yeast Infections**	
☐ **# of pregnancies**	☐ **Number of births**	☐ **Miscarriages**	☐ **Birth Control (type)_____**	
☐ **Menopause**	☐ **Hot flashes**	☐ **Night sweats**	☐ **Vaginal dryness**	
☐ **Increased Libido**	☐ **Decreased Libido**	☐ **No Libido**		

Thank you

ALBERTA HEALTH INSTITUTE

Acupuncture and Chinese Medicine Consent

Client: _____

I voluntarily consent to be treated by _____

I understand that acupuncture include the insertion of sterilized, disposable needles through the skin, or by the application of heat to the skin (moxibustion, heat lamp etc), cupping, electroacupuncture and other techniques within the scope of practice of registered acupuncturist, at certain points on or near the surface of the body.

I am also aware that certain side effects may result from my treatment. These could include, but are not limited to, some local bruising, bleeding, fainting, nausea, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to treatment. If moxibustion is used as part of therapy, there is a risk of burning or scarring from its use.

I accept that no guarantee is made concerning the results of my acupuncture treatments and I have been informed that I may stop at any time. I also understand that Acupuncture and Chinese Medicine is not a substitute for Western medicine, that certain health disorders may require conventional medicine, allopathic medical advice and treatment, either in lieu or concurrently with acupuncture treatments.

I have read the above consent and I understand what it says.

CANCELLATION POLICY

A minimum of 24 hours notice is required is case of cancellation. Otherwise, the full fee for the visit will be charged.

Client Signature: _____

Witness: _____

Date: _____