Name : Today's Date:

_____

Date of Birth: Age:

_____

Address : Postal Code:

_____

Phone: (home) (work) (cell)

_____

Email address:

_____

Emergency Phone Contact: Phone:

_____

Doctor: Phone:

_____

Main issues you would like to address in treatment. Please list your health concerns:

_____
_____
_____

Medications. Please list medications, vitamins and supplements you are currently taking:

_____ _____

Work. Hours per week **Occupation:**

_____

Diet and exercise:
Please briefly describe your current eating and exercise habits.

_____
_____

Chronic Illness, operations, serious accidents. Have you had any serious or chronic illness, operations, or traumatic accidents? If yes, please explain:

_____
_____

Please check (√) current problems, mark with (+) if you had in the past :

General
___ general fatigue

Head and Neck
___ dizziness/light headed
___ fainting
___ headaches/migraines
___ other

Eyes
___ poor vision
___ poor night vision
___ spots/floaters
___ dry eyes
___ red/ burning itchy eyes
___ other

Nose Throat and Mouth
___ bleeding gums
___ chronic sinus infection
___ hay fever or allergies
___ bitter taste in mouth
___ tongue/mouth ulcers
___ grinding teeth
___ nose bleeds
___ dry mouth/thirst
___ prefer warm drinks
___ prefer cold drinks
___other

Respiratory
___chronic cough
___coughing up blood
___coughing up phlegm
___shortness of breath
___wheezing/asthma
___frequent colds
___other

Muscle and Joints
___ joint pain
___ body aches/stiffness
___ numbness/tingling
___ backache
___ knee pain
___ poor balance
___ other

Cardiovascular
___palpitations
___chest pain
___cold hands and feet
___swelling of ankles
___high blood pressure
___low blood pressure
___other

Genito-Urinary
___painful urination
___excessive urination
___scanty urination
___ blood in the urine
___ urgent urination
___ wake up to urinate
___ increased libido
___ decreased libido
___ kidney stones
___ other

Pregnancy
___ leaking amniotic fluid
___ uterine bleeding
___ diabetes (gestational)
___ leg cramps
___ miscarriage
___ nausea /vomiting
___ problems with placenta
___ pre-term labor
___ preeclampsia (toxemia)
___ sciatica
___ multiple pregnancies - twins or more!
___ varicose veins
___ previous cesarean birth

Menstruation:
___ period related mood swings
___ breast distention
___ painful menses
___ menstrual clots
___ heavy menstrual flow
___ light flow
___ irregular menses
___ time between cycles
___ duration of bleeding

Appetite
___ increased appetite
___ decreased appetite
___ loss of desire to eat
___ cravings _____

Gastrointestinal
___ nausea
___ vomiting
___ acid reflux/heartburn
___ gas/flatulence
___ bloating
___ bad breath
___ loose/soft stools
___ constipation
___alternating loose stools/constipation
___laxative use
___food sensitivities
___ intestinal pain/cramping
___hemorrhoids
___other

Emotions
___ sad
___ grief
___ fearful
___ depressed
___ angry/frustrated
___ irritable
___ anxious
___ overthinking
___poor memory
___high stress levels
___other

Sleep
___ insomnia
___ wake up easily/early
___ difficulty falling asleep
___ vivid dreams/nightmares
___ hours of sleep
___ other

Skin
___ hives/rashes
___ eczema/psoriasis
___ acne
___ dryness
___ bruise easily
___other

Anything else you would like me to know?

_____

Acupuncture is generally a safe procedure but bruising, light headedness, and drowsiness may occur following treatment. Avoid strenuous activity after the first treatment. Please inform the practitioner immediately if you experience any symptoms which cause you concern.

Please be aware that 24 hours notice is required for cancellations or changes to appointments so that your time can be made available to another client. Same day cancellations are subject to a fee equal to that of your appointment.

Name of Patient (printed):

_____

Patient Signature Date:

_____ _____