Your Personal Health History

Last name: _____ Given Name:_____
Birth Date: _____ Marital Status: _____
Address: _____ Postal Code:_____
Phone: _____ (Home) _____(Work)_____ (Cell)
Email: _____ Referred By:_____
Physician: _____ Date of last visit: _____

Main Concern(s):

_____

_____

When exploring your body's imbalances do you seek the physical, mental/emotional or spiritual reasoning?

_____

_____

When did you first notice your problem: (please be specific)

_____

_____

Does your condition seem to be getting:
☐Better ☐Worse ☐Remains Constant ☐Comes and goes

Your Health History

1. Please check if you had any of the following in the past year
☐CT Scan ☐MRI ☐X-Ray ☐Ultra Sound ☐Blood Test ☐Angiogram

2. Have you had any major or chronic illness in the past?

_____

3. Please list any surgery or hospitalizations. What were they for and when did they occur?

_____

_____

_____

4. Please list any medications and nutritional supplements you are currently taking:

Name	Dosage	Prescribed by whom	How long
_____	_____	☐MD ☐other	_____
_____	_____	☐MD ☐other	_____
_____	_____	☐MD ☐other	_____

_____ _____ ☐MD ☐other _____

Please check any condition that you have currently (c) or have had in the past (p)

☐Alcoholism
☐Allergies
☐Anemia
☐Angina pectoris
☐Arthritis
☐Asthma
☐Back pain
☐Bladder Disease
☐Bleeding tendency
☐Brittle Nails
☐Bronchitis
☐Bruise Easily
☐Cancer
☐Chest Pain
☐Cold hands/feel
☐Constipation
☐Depression
☐Diabetes
☐Disturbed sleep
☐Dizziness
☐Dry Skin
☐Eczema
☐Edema
☐Emphysema
☐Epilepsy
☐Eye Infections
☐Forgetfulness
☐Gallstones
☐Grinding Teeth
☐Gum or Teeth Problems
☐Hay Fever
☐Hearing Loss
☐Heart Attack
☐Heart Disease
☐Hemophilia
☐Hemorrhoids
☐Hepatitis
☐High Blood Pressure
☐HIV Positive
☐Hives or Rashes
☐Insomnia
☐Irritable Bowel Syndrome
☐Kidney Disease
☐Kidney Stones
☐Leukemia
☐Liver Disease
☐Loose bowel
☐Low Blood Pressure
☐Low Libido/Erectile Dsyfunc.
☐Malaria
☐Migraines
☐Multiple Sclerosis
☐Neuralgia/Neuritis
☐Night Sweats
☐Osteoporosis
☐Palpitations
☐Perspire Easily
☐Pneumonia
☐Reduced Sexual Energy
☐Rheumatic Fever
☐Ringing in Ears
☐Sciatica
☐Sexually Transmitted Diseases
☐Sores in Mouth
☐Stomach Ulcers
☐Stroke
☐Sudden Drops in Energy
☐Sudden loss of weight
☐Tension/Anxiety
☐Thyroid Condition
☐Tonsillitis
☐Tuberculosis
☐Vision Problems
☐Other (please specify) _____

If you are a Woman, when was the date of your last menstrual cycle? _____
On average how many days between each menstrual cycle?_____
How would you best describe your menstrual cycle?

_____

_____

Are you presently being treated by a medical doctor/chiropractor/massage/other? ☐Yes ☐No
By Whom: _____
For which problem: _____

When was the last time you laughed: _____

What are you most grateful for:_____

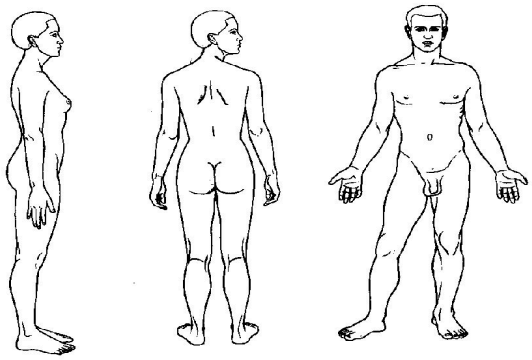
What do you appreciate about yourself most:_____

What type of outlets do you have? (art, cooking, singing, meditation, exercise, prayer, reading,

journaling) _____

What are your Goals over the next month?_____

Please indicate the pain and discomfort areas on the following figures:



Lifestyle

Please be as honest as possible during this portion of the questionnaire. If you feel uncomfortable answering any of the following, leave it blank and it can be discussed during your assessment. ***Remember, all of this information is strictly confidential and can only be released with your written consent.***

Please check if you:

☐Smoke? How many: Per day: _____ Per Week: _____ Per Month: _____

☐Drink? What type: ☐Wine ☐Hard Liquor ☐Beer How often: _____

☐Regularly take Painkillers? What kind: _____ How often:_____

☐Use recreational drugs? What kind: _____ How often:_____

Please rate your current stress level (1= not too much stress, 10= very stressed)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How long have you had this stress level? _____

Informed Consent

Please read the entire consent carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including moxabustion, cupping, point injection, electro-acupuncture, Chinese herbals and other techniques within the scope of practice of acupuncturists.

I understand and am informed that all needles are pre-sterilized and disposable. I further understand and am informed that as in all health care, there are some slight risks to treatment; although all needles are pre-sterilized and disposable. These risks include, but are not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock.

I have read the above consent. I have also had an opportunity to ask questions about its content. By

signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Date (dd/mm/yy)	Patient's Signature

Recommendations and Policies

Thank You for choosing Oliver Chiropractic and Wellness Clinic for your Acupuncture care! We look forward to working with you towards your goal for better Physical, Emotional and Spiritual Health. We have a few recommendations and "housekeeping" requirements to keep You and the Practitioners in a happy & healthy place.

1. Please eat at least once in the 3 hour period before your treatments. We want to make sure your body is nourished and you will be more receptive to our sessions as well.
2. Try not to book more than 2 appointments in a day for yourself, such as other Doctor's appointments, Massage, EFT and/or Workout classes. More is not necessarily better.
3. If you typically drink coffee, pop, alcohol, diet beverages or use any unnecessary pain killers please refrain from consuming these on the day of your sessions with us. Your body is constantly trying to sustain itself. Your system tends to be more receptive to care when it does not have to expend energy trying to eliminate these substances.
4. If you have any questions outside of your booking times that cannot wait until your next session, please email your practitioner or call the clinic 780-455-2112. Our responses typically can take anywhere from 24 hours to 1 week depending on the urgency. So please be patient as we are trying to create a balanced working environment for our practitioners while still recognizing the importance of care.
5. For all treatment sessions we require 48 hours' notice to cancel or reschedule an appointment. If adequate notice is not given, we will charge for the full appointment fee.
6. Lastly, do ten back flips before and after your treatment down Jasper Avenue. (Just wanted to see if you actually read this!)