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 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 write a c or p in the box for any condition that you have currently(c) or have had in the past(p)

☐Alcoholism	☐Epilepsy	☐Low libido
☐Allergies	☐Eye Infections	☐Migraines
☐Anemia	☐Forgetfulness	☐Multiple Sclerosis
☐Anxiety	☐Gallstones	☐Neuralgia/Neuritis
☐Arthritis	☐Grinding Teeth	☐Night Sweats
☐Asthma	☐Gum or Teeth Problems	☐Osteoporosis
☐Back pain	☐Hay Fever	☐Palpitations
☐Bladder Disease	☐Headache	☐Perspire Easily
☐Bleeding tendency	☐Heart Attack	☐Pneumonia
☐Brittle Nails	☐Heart Disease	☐Rheumatoid Arthritis
☐Bronchitis	☐Hemophilia	☐Ringing in Ears
☐Bruise Easily	☐Hemorrhoids	☐Sciatica
☐Cancer	☐Hepatitis	☐Sores in Mouth
☐Chest Pain	☐High Blood Pressure	☐Stomach Ulcers
☐Cold hands/feet	☐HIV Positive	☐Stroke
☐Constipation	☐Hives or Rashes	☐Sudden Drops in Energy
☐Depression	☐Insomnia	☐Sudden weight gain
☐Diabetes	☐Irritable Bowel Syndrome	☐Sudden weight loss
☐Disturbed/poor sleep	☐Kidney Disease	☐Tension
☐Dizziness	☐Kidney Stones	☐Thyroid Condition
☐Dry Skin	☐Leukemia	☐Tonsillitis
☐Eczema	☐Liver Disease	☐Tuberculosis
☐Edema	☐Loose bowel movements	☐Vision Problems
☐Emphysema	☐Low Blood Pressure	

☐Other (please specify) _____

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

What type of exercise are you currently doing?_____
_____

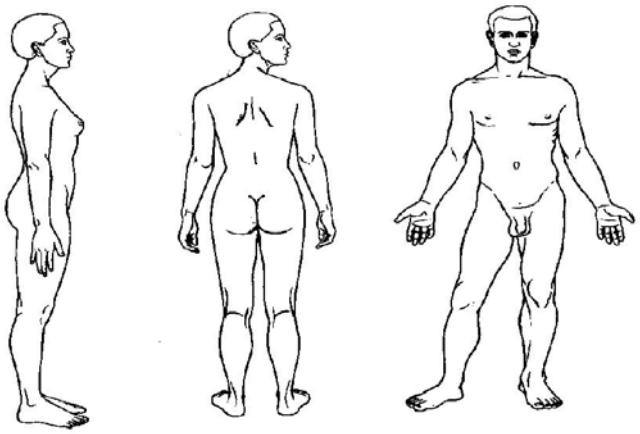
What type of outlets do you have? (art, cooking, singing, meditation, prayer, reading, journaling)
_____

What are your Goals over the next month?_____

Please list any surgical implants you may have (pacemaker, pins, plates, etc) _____
_____

For Women Only: When was the date of your last menstrual cycle? _____
On average how many days between each menstrual cycle?_____
Are you currently pregnant, or are you trying to become pregnant in the near future? ☐Yes ☐No
How would you best describe your menstrual cycle?
_____
_____

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, Gui-sha, Chinese herbals and other techniques within the scope of practice of acupuncturists.

I further understand and am informed that in the practice of acupuncture, 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