



Confidential Patient Health History

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Occupation: _____

Marital Status: _____ Age: _____

Physician: _____ Chiropractor: _____

Emergency Contact: _____

Who referred you? _____

What is your chief complaint or reason(s) for this visit?

When did you first notice symptoms?

What improves the condition?

What worsens the condition?

What treatment have you tried?

Have you received Acupuncture treatments before? YES / NO

Are you willing to take Chinese Herbs if so prescribed by your practitioner? YES / NO

List any Medications or Supplements you are currently taking:

List any medication, food, or environmental substances that you are allergic to, and the reaction you have:

Do you consume caffeine, alcohol, tobacco, or recreational drugs? YES / NO

If YES, how often and how much of each?

Do you exercise regularly? YES / NO

If YES, describe the type of activity you do, and how often you do it:

SYMPTOMS: Check symptoms you currently have, or have had in the past year.

GENERAL	NOSE, THROAT & MOUTH con't	DIGESTIVE SYSTEM
Fatigue	Difficulty in Swallowing	Nausea
Insomnia	Change in Sense of Taste	Vomiting Food
Disturbed Sleep	Tooth or Gum Pain	Vomiting Blood
Frequent Dreams	Bleeding Gum	Diarrhea
Excessive Sleep	Mouth or Tongue Ulcers	Constipation
Dislike Cold	Other:	Loose Stools
Dislike Heat		Bloody / Black Stools
Weight Gain	MUSCLES & JOINTS	Stomach Pain
Weight Loss	<i>Pain, Weakness, or Numbness in:</i>	Abdominal Pain
Fever	Neck / Shoulder / Arm / Hand	Poor Appetite
Chills	Hip / Leg / Feet	Excessive Hunger
Alternating Chills & Fever	Sore Low Back and Knees	Abdominal Bloating / Gas
Night Sweats	Muscle Cramps	Belching
Unusual Daytime Sweats	Body Pain	Indigestion
Unusually Thirsty	Heavy Limbs	Acid Reflux
Seldom Thirsty	Swollen Joints	Haemorrhoids
Edema or Swelling	Hot Joints	
Other:		URINARY / GENITAL
	NERVOUS SYSTEM	Painful Urination
SKIN	Fainting	Difficult Urination
Rashes	Paralysis	Frequent Daytime Urination
Hives	Tremors	Frequent Nighttime Urination
Dry Skin	Poor Balance	Incontinence
Acne	Seizures	Cloudy Urine
Easily Bruised	Other:	Bloody Urine
Changes in Lumps or Moles		Genital Pain or Itching
Unusual Bleeding	HEART, LUNGS & CHEST	Genital Discharge or Lesions
Eczema	Palpitations	Painful Intercourse
Other:	Chest Pain	Low Sexual Drive
	Tightness	Excessive Sexual Drive
HEAD & NECK	Rapid Heart Beat	Other:
Headaches (note type & location of pain)	Swelling of the Ankles	
Dizziness	Cough	MALE
Jaw Pain	Dry Cough	Impotence
Other:	Coughing Up Phlegm	Weak Urinary Stream
	Coughing Up Blood	Prostate Hypertrophy
EYES & EARS	Shortness of Breath	Seminal Emissions
Failing Vision	Asthma / Wheezing	
Blurred Vision	Frequent Colds	FEMALE
Visual Spots	Pain in Rib Cage	Irregular Periods
Night Blindness	Other:	Painful Periods
Eye Pain/Swelling		Bleeding Between Periods
Ringing in the Ears	MENTAL / EMOTIONAL	Passing Clots
Decreased Hearing	Difficulty Concentrating	Scanty Periods
Ear Pain	Poor Memory	Early Periods
Ear Discharge	Worry	No Periods
Other:	Anxiety	PMS
	Depression	Menopausal Symptoms
NOSE, THROAT & MOUTH	Irritability	Abnormal Pap Smear
Nose Bleeds	Frustration or Anger	Breast Lump
Nasal Discharge/Infection	Fearfulness	Breast Pain or Discharge
Frequent Sneezing	Stress	Vaginal Discharge
Change in Sense of Smell	Other:	Other:
Sore Throat		
Hoarseness		

CONDITIONS: Please check conditions you currently have, or have had in the past:

- | | | |
|--|--|--|
| ☐ AIDS | ☐ Fibromyalgia | ☐ Multiple Sclerosis |
| ☐ Alcoholism | ☐ Gallbladder Problem | ☐ /-!.\$ |
| ☐ Allergies | ☐ German Measles | ☐ Pacemaker |
| ☐ Anemia | ☐ Glaucoma | ☐ Pneumonia |
| ☐ Anorexia | ☐ Goiter | ☐ Polio |
| ☐ Arthritis | ☐ Gout | ☐ Prostate Problem |
| ☐ Asthma | ☐ Heart Disease | ☐ Psychiatric Care |
| ☐ Bleeding Disorder | ☐ Hepatitis | ☐ Rheumatic Fever |
| ☐ Bronchitis | ☐ Hernia | ☐ Stroke |
| ☐ +-&'! | ☐ Herpes | ☐ Stomach Disorder |
| ☐ Cancer | ☐ High Blood Pressure | ☐ Thyroid Disorder |
| ☐ Cataracts | ☐ High Cholesterol | ☐ Tuberculosis |
| ☐ Chemical Dependency | ☐ Intestinal Disorder | ☐ Ulcers |
| ☐ Chicken Pox | ☐ Kidney Disease | ☐ Urinary Tract Infection |
| ☐ Chronic Pain | ☐ Liver Disease | ☐ Vaginal Infection |
| ☐ Diabetes | ☐ Lupus | ☐ Venereal Disease |
| ☐ Eczema | ☐ Measles | ☐ Other: |
| ☐ Emphysema | ☐ Menstrual Disorder | ☐ Other: |
| ☐ Epilepsy | ☐ Migraines | ☐ Other: |
| ☐ Fatigue Problem | ☐ Mononucleosis | |

FAMILY HISTORY: Please check if your blood relations have had any of the following:

- | | | |
|--|--|---------------------------------------|
| ☐ Arthritis / Gout | ☐ Diabetes | ☐ Stroke |
| ☐ Asthma | ☐ Heart Disease | ☐ Tuberculosis |
| ☐ Cancer | ☐ High Blood Pressure | ☐ Other: |
| ☐ Chemical Dependency | ☐ Kidney Disease | ☐ Other: |

HOSPITALIZATIONS: Please note if you have ever been hospitalized and why:

WOMEN ONLY: Please answer the following questions if applicable to you.

Pregnancy and Birthing history: Please note the number of pregnancies you have had, the number of deliveries you have had, and any relevant information:

Date of last menstrual period? _____

Age of first menstrual period? _____

Date of onset of menopause? _____

Date of last Pap Smear? _____

Are you pregnant? _____ Are you trying to become pregnant? _____

Are you currently using birth control? What type? _____

Patient Signature: _____

Date: _____

**Acupuncture
Consent to Treatment Form**

By signing below I do hereby consent to be treated with acupuncture and/or Chinese herbs

I understand that section 8(1) of Alberta's Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless

- (a) that person has already consulted with a physician, or in the case of a dental pathology, a dentist, about the condition for which care and treatment from the acupuncturist is being sought;
- (b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition; and
- (c) the acupuncturist has completed a patient consultation form

Have you consulted with a physician or dentist (as appropriate) about the condition for which the acupuncture treatment is now being sought? YES / NO

Acupuncture / Acupressure / Cupping: I understand that acupuncture/acupressure/cupping is performed by the insertion of needles through the skin or by pressure/suction at certain points on the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain, or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Extremely rare but serious problems have been reported in literature such as joint infection, nerve damage, pneumothorax, and needle breakage. I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that Chinese Herbs may be recommended to me in an attempt to treat bodily dysfunction and diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. Should I experience any problems, which I associate with these substances I should suspend taking them and call the acupuncturist as soon as possible.

Electro Acupuncture: I understand that I may be asked to have electro-acupuncture administration. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to, electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **DOB:** _____

Address: _____

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

Phone: _____