New Patient History for Acupuncture

Name

Address | Postal Code

Phone: Home | Cell | Work

Email | Preferred contact for reminders ☐ H ☐ C ☐ W ☐ Email

Marital Status

Age | Birthdate | ☐ Male ☐ Female

Family Physician

Referred to our clinic by

Main Concern

How long have you had this problem? | Have you seen anyone else for this?

What makes it better? | What makes it worse?

Your Medical History:

Medications or vitamins

Surgeries

Diagnosed medical conditions

Drug and food allergies

Serious illness/hospitalizations

Family Medical History

☐ Asthma	☐ Anemia	☐ High Blood Pressure	☐ COPD
☐ Liver Disease	☐ Heart Attack	☐ Obesity	☐ Alcoholism
☐ Osteoporosis	☐ Arthritis	☐ Drug Addiction	☐ Thyroid Disease
☐ Lung problems	☐ Depression	☐ Kidney Disease	☐ Diabetes
☐ Cancer	☐ Stroke		

Please check any that apply to you and indicate how much

☐ Black Tea	☐ Coffee	☐ Pop	☐ Water
☐ Tobacco	☐ Alcohol	☐ Recreational Drugs	

How many meals to you eat a day? | How many snacks a day?

How much do you exercise?

Do you have trouble sleeping at night? ☐ No ☐ Yes

Please check any that apply to you

☐ Loose stools	☐ Insomnia	☐ Always feel hot	☐ Gas
☐ Disturbing dreams	☐ Night sweats	☐ Constipation	☐ Nightmares
☐ Hot flashes	☐ Belching	☐ Anxiety	☐ Bruise easily
☐ Heartburn	☐ Panic attacks	☐ Varicose veins/Spider veins	☐ Indigestion
☐ Depression	☐ Hemorrhoids	☐ Bloating	☐ Mental illness
☐ Uterine prolapse	☐ Easily tired	☐ Poor memory	☐ Anal prolapse
☐ Nausea	☐ Obsessiveness	☐ Ulcers	☐ Vomiting
☐ Dizziness	☐ High blood pressure	☐ Poor appetite	☐ Spots in vision
☐ Headaches	☐ Hearing loss	☐ Eye disease	☐ Migraines
☐ Ringing in ears	☐ Anemia	☐ Numbness	

(continued on other side →)

Please check any that apply to you

☐ Tingling	☐ Cold hands and feet	☐ Snoring	☐ Use blood thinners
☐ Easily angered	☐ Seasonal allergies	☐ Grey hair	☐ Neck pain
☐ Weak knees	☐ Hair loss	☐ Shoulder pain	☐ Physical weakness
☐ Osteoporosis	☐ Back pain	☐ Low sex drive	☐ Arthritis
☐ Hip pain	☐ Swollen legs	☐ Dark urine	☐ Knee pain
☐ Need daily naps	☐ Cloudy urine	☐ Ankle/foot pain	☐ Always feel cold
☐ Urinary pain	☐ Arm pain	☐ Always thirsty	☐ Dribbling urine
☐ Wrist/hand pain	☐ Thirsty at night	☐ Night urination	☐ Abdominal pain
☐ No thirst	☐ Urinary frequency	☐ Recent antibiotic use?	☐ Weak voice
☐ Short of breath	☐ Cough	☐ Heart disease	☐ Asthma
☐ Nasal congestion	☐ High cholesterol	☐ Emphysema	☐ Bronchitis
☐ Chest pain	☐ Wheezing	☐ Hoarse voice	☐ Palpitations
☐ Hepatitis	☐ Fever	☐ Eczema	☐ STD's
☐ Chills	☐ Skin rash	☐ HIV/AIDS	☐ Sore throat
☐ Acne	☐ Genital warts	☐ Sinus pain	☐ Frequent nosebleeds
☐ Any metal implants in your body?			

Women Only:

Number of pregnancies	Number of births	Miscarriages	Abortions
Date of last period	How many days is the flow?	Number of days between periods	
☐ Heavy flow	☐ Light flow	☐ Clots	Colour of flow
☐ Infertility	☐ Menopause	☐ Hysterectomy	☐ Irregular periods
Do you have PMS symptoms:	☐ Irritable ☐ Crying	☐ Angry	
	☐ Back pain ☐ Cramping	☐ Breast tenderness	
☐ Uterine Fibroids	☐ Spotting between periods	☐ Frequent vaginal discharge	☐ Yeast infections
☐ Endometriosis	☐ Ovarian Cysts		
☐ IUD	☐ Hormone cream/HRT	☐ Birth control pills	☐ Birth control patch

Are you pregnant? ☐ No ☐ Yes If yes, due date:

Men Only:

☐ Impotence	☐ Erectile dysfunction	☐ Premature ejaculation	☐ Prostate problems
☐ Infertility	☐ Testicle pain/swelling	☐ Viagra use	☐ Penile implant

Do you have regular prostate exams? ☐ No ☐ Yes If yes, date of last exam:

Men and Women: Please list any other concerns or problems: