Date: ____ / ____ / ______

Name:				Gender:	Age:
Address:		City:	Prov:	Postal Code:	
Home Phone #:	Other Phone #: Work Cell Other	Email:			
Date of Birth:	Emergency contact:	Contact #:		Relationship:	
Height:	Weight:	Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other :__________			
Employer:		Occupation:			
Physician:		Physician's Phone #:			
How did you hear of our clinic?		Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ____/____/____			

MAIN CONCERNS

Please write in up to 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ______________________________

When did this start? _______________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |————|————| 10

2 ______________________________

When did this start? _______________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |————|————| 10

3 ______________________________

When did this start? _______________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |————|————| 10

HEALTH HISTORY

Circle the (person icon) if you have / had the condition and note the year it started.
Circle the (family icon) if there is a family history of the condition.

Condition	YOU	Year	FAMILY
Cancer *type(s)?* ______________	☐	______	☐
Diabetes	☐	______	☐
Hepatitis	☐	______	☐
High Blood Pressure	☐	______	☐
Heart Disease	☐	______	☐
Stroke	☐	______	☐
Seizure Disorder	☐	______	☐
Thyroid Disease	☐	______	☐
Asthma	☐	______	☐
Pacemaker	☐		☐
Osteoporosis	☐	______	☐
Herpes	☐	______	☐
AIDS / HIV	☐	______	☐
Other STD	☐	______	☐
Rheumatic Fever	☐	______	☐
Alcoholism	☐	______	☐
Allergies *type(s)?* ______________	☐	______	☐
Mental Illness	☐	______	☐
Kidney Disease	☐	______	☐
Anemia	☐	______	☐

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	__________	______
Soda	__________	______
Tobacco	__________	______
Alcohol	__________	______
Drugs	__________	______

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No

If so, what and how often:

____

____

____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

MEDICATONS

Please note what medications, herbs or supplements that you take regularly

____

____

____

INJURIES & SURGURIES

Please note what happened to what body area and when it occurred (incl. dental)

____

____

____

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD |———————|———————| HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

Thirst for cold / hot drinks
- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Unusual sweats

When_______am / pm
Where on body_________

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY |———————|———————| OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds
- ☐ Edema / Swelling _____________
- ☐ Rashes _____________________
- ☐ Itching ______________________
- ☐ Dandruff

Where on your body?:

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA |———————|———————| CONSTIPATION

BM: How often? _____x / every _____days

Stools keep shape? ☐ Y ☐ N

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger
- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW |———————|———————| HIGH

- ☐ Sudden energy drop

Time of day: _____ am / pm

- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

SLEEP

\# hours per night ______

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?*_______
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS NOSE THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (*color*_______)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

MENSES (IF APPLICABLE)

MENOPAUSE

Age at last menses : _________

Year changes began: ________

- ☐ Hot flashes _____x / day
- ☐ Night sweats _____x / week
- ☐ Vaginal dryness
- ☐ Loss of sex drive

Age at first menses: ______

Length of full cycle: ______ days

Length of menses: ____ days

Last menses start date: ____ / ____

\# of pregnancies: ____

\# of births: ____ premature ____

\# of abortions / miscarriages: ____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation (PMS)
- ☐ Cramps
  - ☐ Before bleeding
  - ☐ First day
  - ☐ During period
- ☐ Clots
- ☐ Breast tenderness
- ☐ Mood changes
- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Midcycle spotting
- ☐ Yeast infections
- ☐ Birth control pill (hormonal)

URINARY (IF APPLICABLE)

Fluid in = fluid out? ☐ Y ☐ N

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

REPRODUCTIVE (IF APPLICABLE)

Are you sexually active? ☐ Y ☐ N

- ☐ Change of sexual drive: ⇧ ⇩
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture at Stillpoint Community Acupuncture (SCA), by a registered acupuncturist. I understand that acupuncturists practicing in the province of British Columbia are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by SCA.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of 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.

Possible risk: 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. 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.

24 hour cancellation policy: I understand that SCA has a 24 cancellation policy, and agree to give a minimum of 24 hours' notice when changing or canceling an appointment. Canceled appointments without 24 hours notice will be charged $15.

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: ___________________________ **Date of Birth:** _____________________