KoreEnergy
WELLNESS
bringing out your best naturally
connect. heal. thrive

CONSULTATION

Kore~Energy Wellness
3190 Ridgeway Dr., Unit 35
Mississauga, ON L5L 5S8
Tel: (905) 369-5433
www.koreenergy.ca

Patient Name: _____ Date: _____

REASON FOR VISIT: _____

_____

_____

How long? _____ How often? _____

Is there any other health problem that concerns you besides your major complaint even if you never considered an acupuncturist could help? For example, do you have any sinus problems, hormone problems, asthma, diabetes, digestive troubles, arthritis, fatigue, mood swings, troubles with sleep or any other problems at all that you wish you could get rid of?

_____

_____

Since the time you first had any of these problems, what, if anything, have you tried? _____

_____

How do your health problems affect your job performance? Explain? _____

_____

What hobbies or interests do you have outside of work? _____

_____

Do you have:			
	1. Trouble falling asleep?	[ ]Yes	[ ]No
	2. Not rested when waking?	[ ]Yes	[ ]No
	3. Frequent wakening during the night?	[ ]Yes	[ ]No
	4. Waking and not being able to fall back asleep?	[ ]Yes	[ ]No
	5. A bowel movement at least once every day?	[ ]Yes	[ ]No
	6. A good appetite and desire to eat?	[ ]Yes	[ ]No
	7. Bloating or digestive problems?	[ ]Yes	[ ]No
	8. Physically active at least 3 times/week?	[ ]Yes	[ ]No
	9. Often catching cold or feeling under the weather?	[ ]Yes	[ ]No
	10. Lack of motivation and/or depression?	[ ]Yes	[ ]No

Other Comments or Concerns regarding your health (medications, past injuries, concerns, etc):

_____

_____

_____

Signature of Patient (or parent/guardian)

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EXAMINATION

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How was your childhood health? _____

Hospital Visits/Stays? _____

Recent tests (please indicate test results and date below)?

[ ] Physical	[ ] Cholesterol	[ ] Prostate	[ ] Blood
[ ] HIV/STD	[ ] Pap smear	[ ] Mammography	[ ] Other: _____

Test Results and Date: _____

Check any/all you have had in the past:

[ ] Diabetes	[ ] Allergies	[ ] Glaucoma	[ ] Rheumatic Fever
[ ] Heart Disease	[ ] CVA (Stroke)	[ ] Vein condition	[ ] Thyroid disorder
[ ] Asthma	[ ] Pneumonia	[ ] Tuberculosis	[ ] Emphysema
[ ] Jaundice	[ ] Gonorrhea	[ ] Mumps	[ ] Bleeding tendency
[ ] Syphilis	[ ] Measles	[ ] Chicken Pox	[ ] Nervous disorder
[ ] Meningitis	[ ] HIV	[ ] Polio	[ ] Mononucleosis
[ ] Epilepsy	[ ] High fever	[ ] Hepatitis	[ ] Multiple Sclerosis
[ ] Paralysis	[ ] Cancer	[ ] Migraines	[ ] High blood pressure
[ ] Other Lung illnesses	[ ] Other Liver illnesses	[ ] Other Heart illnesses	[ ] Other Kidney illnesses

Other: _____

Surgeries: _____

Please clearly describe any areas of pain: _____

_____

Describe the pain:
[ ] Sharp [ ] Burning [ ] Aching [ ] Dull [ ] Moving [ ] Fixed [ ] Other:_____

Do the following lessen the pain?
[ ] Pressure [ ] Cold [ ] Heat [ ] Exercise [ ] Other:_____

Do the following worsen the pain?
[ ] Pressure [ ] Cold [ ] Heat [ ] Other:_____

PLEASE CHECK THE FOLLOWING THAT CURRENTLY PERTAIN TO YOU:

Overall Temperature (Kidney function):

[ ] Cold Hands	[ ] Cold Feet	[ ] Sweaty Hands	[ ] Sweaty Feet
[ ] Afternoon flushes	[ ] Night sweats	[ ] Lack of perspiration	[ ] Thirsty
[ ] Perspire easily	[ ] Hot body	[ ] Cold body	[ ] Heat in hands, feet, and chest
[ ] Hot flashes any time of the day			

Overall Energy (Lung, Kidney function):

[ ] Shortness of breath	[ ] Low energy	[ ] General weakness	[ ] Easily catch colds
[ ] Difficulty keeping eyes open in the daytime		[ ] Feel worse after exercise	

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Overall Blood (Liver, Spleen, Heart function):
[ ] Dizziness [ ] See floating spots

Heart function:
[ ] Palpitations [ ] Anxiety [ ] Restlessness [ ] Mental confusion
[ ] Frequent dreams [ ] Wake unrefreshed [ ] Chest pain travelling to shoulder
[ ] Drink coffee (# of cups per week: _____) [ ] Sores on the tip of the tongue

Lung function:
[ ] Nasal Discharge (Colour:_____) [ ] Cough [ ] Nose Bleeds
[ ] Sinus Congestion [ ] Dry mouth [ ] Dry throat
[ ] Allergies (To what?_____) [ ] Dry Skin [ ] Dry Nose
[ ] Headaches (Location:_____) [ ] Sneezing [ ] Alternating fever and chills
[ ] Overall achy feeling in the body [ ] Stiff neck [ ] Stiff shoulders
[ ] Smoke cigarettes (# per day:_____) [ ] Difficulty breathing [ ] Sore throat
[ ] Sadness [ ] Melancholy

Spleen function:
[ ] Low appetite [ ] Abrupt weight gain [ ] Abrupt weight loss [ ] Abdominal bloating
[ ] Abdominal gas [ ] Gurgling in stomach [ ] Fatigue after eating [ ] Easily bruised
[ ] Hemorrhoids [ ] Pensive [ ] Over-thinking [ ] Worry
[ ] Prolapsed organs (previously diagnosed, which organ? _____)

Spleen, Stomach, Large Intestine, Small Intestine function:
[ ] Loose stool [ ] Constipated [ ] Incomplete [ ] Diarrhea
[ ] Blood in stools [ ] Mucous in stools [ ] Undigested food in stools

Dampness trapped in the body:
[ ] General sensation of heaviness in the body [ ] Mental heaviness [ ] Mental sluggishness
[ ] Mental fogginess [ ] Swollen hands [ ] Swollen feet [ ] Swollen joints
[ ] Chest congestion [ ] Nausea [ ] Snoring

Liver, Gall Bladder function:
[ ] Alternating diarrhea and constipation [ ] Chest pain [ ] Tight sensation in the chest
[ ] Bitter taste in mouth [ ] Anger easily [ ] Frustration [ ] Depression
[ ] Irritability [ ] Skin rashes [ ] Tingling sensation [ ] Numbness
[ ] Muscle spasms [ ] Muscle twitching [ ] Muscle cramping [ ] Seizures
[ ] Convulsions [ ] Lump in the throat [ ] Neck tension [ ] Limited range of motion, neck
[ ] Shoulder tension [ ] Limited range of motion, shoulder [ ] Drink alcohol
[ ] High-pitched ringing in the ears [ ] Gall stones [ ] Headache at top of head

Stomach function:
[ ] Large appetite [ ] Bad breath [ ] Mouth (canker) sores [ ] Bleeding, swollen or painful gums
[ ] Heartburn [ ] Acid regurgitation [ ] Ulcer (diagnosed) [ ] Belching
[ ] Hiccoughs [ ] Stomach pain [ ] Vomiting

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Eyes (Liver function):

[ ] Itchy [ ] Bloodshot [ ] Hot [ ] Dry
[ ] Watery [ ] Gritty [ ] Blurry vision [ ] Decreased night vision

Kidney, Urinary Bladder function:

[ ] Frequent cavities [ ] Easily broken bones [ ] Sore knees [ ] Weak knees
[ ] Cold knees [ ] Low back pain [ ] Memory problems [ ] Excessive hair loss
[ ] Kidney stones [ ] Bladder infections [ ] Easily startled [ ] Lack of bladder control
[ ] Wake during the night twice or more to urinate [ ] Low-pitched ringing in the ears

Urination:

[ ] Normal colour [ ] Dark yellow [ ] Clear [ ] Reddish [ ] Cloudy
[ ] Scanty [ ] Profuse [ ] Strong odour [ ] Burning [ ] Painful
[ ] Discharge [ ] Difficult [ ] Painful [ ] Urgent [ ] Frequent

Libido:

[ ] Normal [ ] High [ ] Low

WOMEN ONLY:

Regular menstrual cycle [ ]Yes [ ]No Pregnant? [ ]Yes [ ]No Number of children:_____
Number of pregnancies: _____ Age of first menstruation:_____ Age of menopause:_____
Average # of days of flow: _____ Average days in entire cycle:_____
[ ] Vaginal discharge [ ] Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

[ ] Nausea [ ] Vomiting [ ] Water retention [ ] Breast swelling
[ ] Food cravings [ ] Headaches [ ] Migraines [ ] Breast tenderness
[ ] Depression [ ] Irritability [ ] Anxiety [ ] Other emotions: _____
[ ] Dull pain, where? _____ [ ] Sharp pain, where? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Colour (normal, bright red, pale, brown, rust, dark, purple)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp)							
Clots (large, small, black, purple, red)							
Vomiting (check if Yes)							
Nausea (check if Yes)							
Other							

MEN ONLY:

[ ] Swollen testes [ ] Testicular pain [ ] Impotence [ ] Premature ejaculation
[ ] Feeling of coldness or numbness in external genitalia [ ] Other: _____