

Patient Information form (Please Print)

Name:

Date of Birth:

How do you identify? Male Female Two-spirit Transgendered Intersexed

Are you indigenous? If so, please identify

Address

Postal Code:

Phone: (H)

(W)

(Cell)

Email:

Would you like to join our newsletter? (please check) Yes No

Family Doctor:

Tel:

Emergency Contact Name:

Tel:

How did you hear of us:

What benefits would you like to get from receiving Acupuncture/Laser?

What is your Chief Complaint?

How long have you suffered with the complaint?

What is your current diagnosis?

What is your Secondary Complaint?

What is your stress level(1- none 10- very stressful) Occupational Personal

What is your current occupation?

How many hours do you work?

How was your general health as a child?

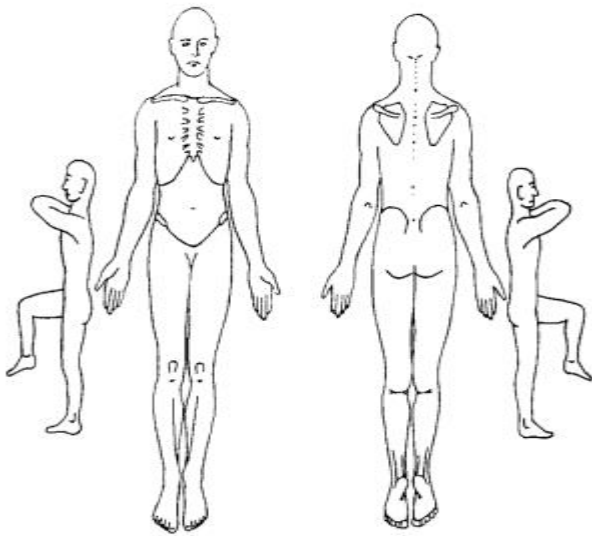
What is season do you like most?

what season do you dislike?

What color do you like most?

what color do you dislike most?

Do you have pain? Please circle.



Constant () Comes & Goes () Fixed () Moves ()

Unilateral ()

Dull () Sharp () Burning () Aching () Spastic ()

Numb ()

Better: Heat () Cold () Motion () Rest () Pressure ()

am / pm

Worse: Heat () Cold () Motion () Rest ()

Pressure () am / pm

SCALE 0 1 2 3 4 5 6 7 8 9 10

Medical History

Current Medications (prescription & over the counter), Supplements, Herbs or Homeopathic Remedies

Family Health Status(please check):

Tuberculosis () Seizures () Cancer () Type of cancer Kidney Disorders () Heart Disease ()

Asthma () High Blood Pressure () Skin Disorders () High Cholesterol () Mental/emotions disorders ()

Diabetes () Stroke () Other (please specify)

Do you Frequently Experience Any of these Emotional Behaviors:

Anger () Anxiety () Bitterness () Depression () Stress () Fear () Impatience () Impulsiveness ()

Irritability () Jealousy () Mood Swings () OCD () Over Excitement () Worry () Sadness ()

How is you energy level ?

When is your energy at its highest level?

Lowest level?

When was the last time your energy was consistently good?

Is there any possibility you may be pregnant? if so, how far along are you

Are you receiving or seeking any other type of therapy for your current concern?

Have you ever been Hospitalized? Or had any surgeries? If so what was the reason, and the date?

What are your typical eating habits?

Skip Meal(s) () Eat in a Rush () Eat When Not Hungry () Eat too Fast () Eat Late at Night ()

Cannot/Can eat when Worried/Stressed () Excess Hunger () No Desire to Eat ()

How much do you consume per day of?

Water Coffee Tea Soda Alcohol Cigarettes Other)

Craving specific food(s):

Cold () Hot () Room temperature () Bitter () Spicy () Sweet () Greasy () Salty () Sour ()

Do you have any comments about you diet

Do you exercise? If so, what type of Exercise?

How often? (per week, per day)

What is your approximate: Height Weight

Are you concerned about weight gain? YES or NO

Do you have any sleep disturbances?

Insomnia () Waking Easily () Waking Early () Not feeling rested upon waking () Dream-disturbed sleep () Falling asleep during the day () Difficulty failing asleep () Waking frequently () Difficulty waking ()

How many hours do you generally sleep each night?

Please place a check beside anything you currently have or have had in the past

AIDS ()	Celiac ()	Hepatitis ()	Pancreatitis ()
Alcoholism ()	Cataracts ()	Intestinal Disorder ()	Parkinson's ()
Allergies ()	Chicken Pox ()	Impotence ()	Pneumonia ()
Anemia ()	Chronic Fatigue ()	Kidney Disease ()	Polio ()
Attention Deficit Dis. ()	Chronic Pain ()	Liver Disease ()	Prostate Disorder ()
Arthritis ()	Diabetes ()	Lupus ()	Scarlet Fever ()
Appendicitis ()	Emphysema ()	Lyme Disease ()	Rheumatoid ()
Arteriosclerosis ()	Epilepsy ()	Meningitis ()	Stomach Disorder ()
Bladder Disease ()	Gallbladder problems ()	Measles ()	Stroke ()
Bronchitis ()	German Measles ()	Mononucleosis ()	Thyroid Disorder ()
Bleeding disorder ()	Goiter ()	Multiple Sclerosis ()	Tonsillitis ()
Broken Bones ()	Gout ()	Mumps ()	Tuberculosis ()
Bulimia ()	Hernia ()	Osteoarthritis ()	Ulcers ()
Cancer ()	High Cholesterol ()	Osteoporosis ()	Other ()
Candidiasis ()	Herpes ()	Obsessive Compulsive Disorder ()	

General Symptoms

Aversion to wind, cold, heat ()	Fatigue ()	Poor memory ()
Body Heaviness ()	Fever ()	Night Sweats ()
Bruise Easily ()	Heart Burn/Reflux ()	Sweats Easily ()
Cold Hands/ Feet ()	Often feeling warm/hot ()	Spontaneous Sweating ()
Chills ()	Often feeling cold ()	Verigo ()
Circulation ()	Poor Appetite ()	Weight loss/gain ()
Excess Dreaming ()	Poor Sleep ()	Weakness / lack of stamina ()

Head - Eyes, Ears, Nose, Mouth, Throat

Headaches ()	excess Phlegm ()	Teeth Issues ()	Gum Problems ()
Migraines ()	eye pain/strain ()	Nose Bleeds ()	Grinding of teeth ()
Dizziness ()	Colour blindness ()	Sinus Problems ()	Swollen Glands ()
Facial Tics/paralysis ()	Cataracts ()	Post nasal drip ()	Glaucoma ()
Concussions ()	Poor vision/glasses ()	Poor sense of smell ()	High/ Low Pitch ()
Ringing in the ears ()	Blurred Vision ()	Nasal polyps ()	Itchy eyes ()
Poor hearing ()	floaters/spots ()	Sore Throat (recurring) ()	Facial Pain ()
Earaches/infection ()	Dry eyes ()	Difficulty Swallowing ()	Excess Saliva ()
TMJ ()	Red/burning eyes ()	Dry mouth/throat ()	Bitter Taste ()
Jaw problems ()	watery eyes ()	Mouth sores/ulcers ()	

Respiratory

Asthma/Wheezing ()	Cough + Blood ()	Heavy Chest ()	Short of Breath ()
COPD ()	Cough + Phlegm ()	Tight Chest ()	
Cough ()	Difficult Breathing ()	Pneumonia ()	

Gastrointestinal:

Abdominal Pain ()	Bloating ()	Gas ()	Mucus in Stool ()
Bad Breath ()	Bloody Stool ()	Hiccups ()	Nausea/Vomiting()
Constipation ()	Diarrhea ()	Hemorrhoids ()	Rectal Pain ()

Cardiovascular:

Blood Clots ()	High Blood Pressure ()	Low Blood Pressure ()	Phlebitis ()
Chest Pain ()	High Cholesterol ()	Pace Maker ()	
Fainting ()	Irregular Heart Beat ()	Palpitations ()	

Musculoskeletal:

Arthritis ()	Limited Use ()	Neck Pain ()	Weight Gain ()
Atrophy ()	Low Back Pain ()	Rib Pain ()	Weight Loss ()
Joint Pain ()	Muscle Pain ()	Scoliosis ()	
Limited Motion ()	Muscle Cramps ()	Upper Back Pain ()	

Genito-Urinary:

Bed Wetting ()	Impotence ()	Nocturnal Emissions ()	Urgent Urination ()
Bladder Infections ()	Incomplete Urination ()	Painful Urination ()	Wake to Urinate ()
Bloody Urine ()	Kidney Stones ()	Premature Ejaculation ()	Yeast Infections ()
Frequent Urination ()	Libido Issues ()	Unable to Hold Urine ()	Pale Urine ()
Dark Urine ()	Cloudy Urine ()		

Gynecological:

Breast Lumps ()	Genital Swelling ()	Light Periods ()	PMS ()
Blood Clots ()	Heavy Periods ()	Menopause ()	Genital Discharge ()
Genital Burning ()	Hysterectomy ()	# Miscarriages ()	Color: ()
Genital Itching ()	Infertility ()	# Pregnancies ()	

Neuro-Psychological:

Addiction()	Easily Stressed ()	Numbness ()	Seizures ()
Anxiety ()	Irritability ()	Poor coordination ()	
Depression ()	Mental Illness ()	Poor Memory ()	

Skin & Hair:

Acne ()	Discolorations ()	Hot Flashes ()	Rashes ()
Burning Skin ()	Eczema ()	Hives ()	Shingles ()
Dermatitis ()	Hair Loss ()	Itchy / Dry Skin ()	Warts ()
Dandruff ()	Fungal Infection ()	Psoriasis ()	

Is there anything you want to tell me?