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| Name:  | Date of birth:  |
| Relationship status:  | Children:  |  |
| Address |  |
| Phone |  |
| Email |  |
| How did you hear about Healing Via Acupuncture?  |  |
| Emergency contact |  |
| Family doctor  |  |
| Date of last physical check-up  |  |
| Current medications and conditions they are treating |  |
| Reasons for today’s visit in order of importance | 2. 3.  |
| Is it getting worse?  | Yes / No |
| What seemed to be the initial cause?  |  |
| What makes it better ? |  |
| What makes it worse?  |  |
| Please list other past or currents treatments used for this condition  |  |
| Family Medical History  |  Please i*ndicate if you or a close relative (parent, sibling) have any of the following:* AllergiesAsthma DiabetesKidney DiseaseBirth DefectsJuvenile ArthritisOther |
| Surgeries  | Please list year, reason and hospital |
| Other trauma or hospitalisation (Car accidents, falls, etc) |  |
| Other conditions | Please indicate if any apply with a **P**= Past **C**= Current **F**= FamilyHeadachesDizziness / FaintingJaw PainArthritisSkin Condition Contagious Illness Respiratory DisorderHeart ConditionStrokeKidney DisorderLow / High Blood Pressure DiabetesDeep Vein Thrombosis Neurological ConditionSpinal / Head injury CancerHepatitisShinglesAIDSSprain/ Strain/ Fracture Osteoporosis |
| **Body system review** |
| Headache | Location: Type of pain: How often: Dizziness:  |
| Eyes | Red: Itchy: Watery: Blurry: Are you wearing glasses/contact? |
| Ears | Ringing: If yes, is the pitch high or low?  |
| Teeth/ Gum | Bleeding: Loose: Clenching:  |
| Lungs | Shortness of breath: Cough: Sputum:  |
| Heart:  | Palpitations: Heaviness: Burning:  |
| Other information if any (hair loss, nails, skin etc.) |  |
| Body temperature & perspiration  | Hot / ColdWhere:Chills: Hot flashes: Night sweats: Spontaneous sweating Other:  |
| Diet & Thirst  | Please complete the sample menu according to an average dayMorning :Noon :Evenings :Snacks :Beverage TypesAmount / type Beverage : |
| Any restrictions?Food allergies? |  |
| What do you NOT eat and how does it affect you? (e.g Bloating, Gas, Tired..) |  |
| Do you eat any of the following, and if yes how often?  | Dairy Frozen treats / drinks Raw Vegetables Cold / Hot Drinks (preference?)  |
| Cravings | Sweet / Salty / Sour / Bitter / Spicy |
| Hunger | Frequently hungry / Normal / No appetite  |
| **Elimination** |  |
| Urine | Colour: Blood: Cloudy: Urgent: Burning: Night time / how often : |
| Stools | Frequency/ day : Hard or loose : Constipation / diarrhoea : Difficulty : Undigested food in stools: Blood: Mucus: Other:  |
| Nausea/vomiting? |  |
| Acid reflux/ Indigestion? |  |

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| Sleep  | Time falling asleep: Time waking: Trouble falling asleep : Waking in the night (if yes, what time?): Trouble falling back to sleep: Dreams: Worries/thoughts: Other:  |
| Emotions  | Please check off what you feel in a month, answer by Y or N)Mood Swings Anxiety Depression Frustration Worry Irritability Sadness |
| Stress Level | Between 1-10 : |
| Alcohol usePer day/ week |  |
| Smoking  | Please indicate if you used to smoke, or still do, and for how long |
| Drugs use |  |
| Energy levels | Between 1-10 : |
| Exercise | No ExerciseMild Exercise *(active increase in heart rate more than 2 times a week, walk short distance, golf, climb stairs)*Moderate Exercise *(Less than 4x week for at least 30 minutes)* Intensive Exercise *(4 or more times a week for more than 30 minutes)*Please list activities and duration: |
| If you are menstruating: | Method of contraception:Menstruation – regular/irregular/stopped? Cycle length: Heavy/scanty bleeding: Number of days: Dark or light in colour: Blood clots: PMS:Period pains/cramps: Vaginal discharge: If yes, please indicate colour, odour, amount etc. Any previous gynaecological diseases or operations?History of pregnancy: Miscarriage: |
| Please add here anything that you feel is important for me to know : |  |

Please send this form via email to eugenievg@gmail.com

*Thanks for taking the time to fill this form,*

*See you soon at the practice!*

*Eugénie*