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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:*  Allergies  Asthma Diabetes  Kidney Disease  Birth Defects  Juvenile Arthritis  Other | | |
| 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**= Family  Headaches  Dizziness / Fainting  Jaw Pain  Arthritis  Skin Condition  Contagious Illness  Respiratory Disorder  Heart Condition  Stroke  Kidney Disorder  Low / High Blood Pressure  Diabetes  Deep Vein Thrombosis  Neurological Condition  Spinal / Head injury  Cancer  Hepatitis  Shingles  AIDS  Sprain/ 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 / Cold  Where:  Chills:  Hot flashes:  Night sweats:  Spontaneous sweating  Other: | | |
| Diet & Thirst | Please complete the sample menu according to an average day  Morning :  Noon :  Evenings :  Snacks :  Beverage Types  Amount / 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? |  | | |

|  |  |
| --- | --- |
| 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 use  Per 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 Exercise  Mild 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*