Date: _____

PERSONAL INFORMATION

Name: _____ _____ _____
(Last Name) (First Name) (Middle Name)

Health Number: _____ **Date of Birth:** _____ **Place of Birth:** _____
(DD/MM/YYYY)

Address: _____
(Street) (City) (Province) (Postal Code)

Phone Number: _____ **Occupation:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Number of Children:** _____

Emergency Contact: _____
(Name) (Phone Number)

How did you hear about the clinic? _____

PRESENTING COMPLAINT

What is your reason for seeking acupuncture treatment: _____

How long have you had this condition? _____

What seems to help this problem? ☐ Heat ☐ Ice ☐ Other _____ ☐ Nothing

What makes the problem worse? _____

Is this condition getting: ☐ Better ☐ Worse ☐ Constant ☐ Comes and Goes ☐ Other _____

Describe any previous treatments sought for this problem: _____

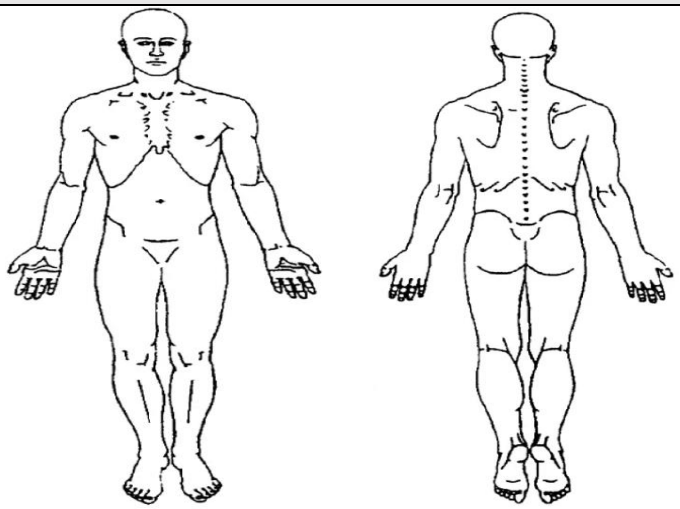
Please list any other problems you would like to discuss with the practitioner: _____

_____

PAIN DIAGRAM

On the diagram, please circle the areas of concern and indicate the quality of pain you are experiencing.

(Sharp, dull, ache, stab, burn, shooting, numb, throb, tingle etc.)



LIFESTYLE INFORMATION

Do you smoke? ☐ Yes ☐ No Packs per day: _____ Drink coffee? ☐ Yes ☐ No Cups per day: _____

Do you consume alcohol? ☐ Yes ☐ No Drinks per week: _____ Do you gamble? ☐ Yes ☐ No

My fitness level is: ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

I exercise _____ hours per week at: ☐ mild ☐ moderate ☐ strenuous intensity.

I exercise by doing: _____

I sleep _____ hours per night. Do you awake rested? ☐ Yes ☐ No

Is your life stressful? ☐ Yes ☐ No How do you deal with stress? _____

Last time I felt great was: _____

How would you rate your emotional/psychological health? (1-10, 10 being excellent) _____

Have you ever had an unwanted sexual experience? ☐ Yes ☐ No

Have you ever experienced abuse? ☐ Yes ☐ No If yes, please check:

☐ Emotional ☐ Physical ☐ Sexual ☐ Mental ☐ Spiritual

Are you or have you ever been depressed? ☐ Yes ☐ No Medications taken: _____

Do you have a counselor? ☐ Yes ☐ No What do you do for self-care? _____

HEALTH CONDITIONS

Previous health care experience: (please check)

☐ Chiropractor ☐ Naturopath ☐ Massage Therapy ☐ Cranio-Sacral ☐ Other: _____

Doctor's Name: _____ Phone Number: _____

Please state if the following health conditions relate to you presently (✓), in the past (P), or family history (H):

CONDITITON	
Arthritis	
Arm Pain	
Back Pain	
Hip Pain	
Leg Pain	
Neck Pain	
Shoulder Pain	

CONDITITON	
Cancer	
Depression	
Diabetes	
Headache	
Infectious Disease	
Menstrual Problems	
Nervous Disorder	

CONDITITON	
Abdominal Pain	
Constipation	
Diarrhea	
Gas/Bloating	
Urinary Problems	
Vomiting	
Weight Problems	

Allergies	
Asthma	
Cough	
Difficulty Breathing	
Sinus Infection	
Spitting Blood	
Tuberculosis	
Skin Condition	
Lupus	

Clumsiness	
Convulsions	
Dizziness	
Double Vision	
Epilepsy	
Fainting	
Lightheaded	
Visual Problems	
Sexual Problems	

Bruise Easily	
Chest Pain	
Bleeding Disorders	
Hardening of Arteries	
Heart Attack	
High/Low Blood Pressure	
Stroke	
Heart Disease/Pacemaker	
Varicose Veins / Hemorrhoids	