Living Path Acupuncture & Wellness

DATE (DD) (MM) (YYYY)

Legal Name

Preferred Name Occupation

Date of Birth (DD) (MM) (YYYY) Gender

PERSONAL INFORMATION

☐ Please check here if you do **NOT** wish to receive email updates

Phone #	Email	
Address		Apt#
City	Province	Postal Code
Emergency Contact	Emergency Phone #	
Physician Name	Physician Phone #	

MAIN CONCERN/ REASON FOR VISIT

When did it start? What makes it better or worse?

HEALTH HISTORY (if you need more space, please ask for a second form

Major illnesses you have had

Major illnesses in your family

Meds & Supplements	For what conditions	When you started

Allergies

List all surgeries, injuries, traumas and date

Other treatments you are presently receiving

LIFESTYLE AND HABITS

Please list any special dietary habits and years (e.g., vegetarian, vegan, raw, etc.)

Do you consume? How often/how much?

Coffee

Tea

Alcohol

Soda

Tobacco

Other

Sports, Physical Activity & how often

Energy Level (from 1-10)

Do you feel? (please mark on scale)

Cold ——■—— Hot

PLEASE CHECK OR FILL IN ALL THAT APPLY. **C = Chronic R = Recent**

Check **C** for **CHRONIC**, recurring or long-standing problems that you may or may not be experiencing now.

Check **R** for **RECENT** problems that you are experiencing at the moment, or have experienced very recently.

C	R	MUSCULOSKELETAL
		Neck
		Back
		Knee/ Leg
		Shoulder/ Arm
		Hand/ Wrist
		Foot/ Ankle
		Scoliosis
		Bursitis
		Tendonitis
		Sciatic Pain
		Arthritis
		TMJ
		Degenerating disc disease
		Osteoporosis
		Fibromyalgia
		Chronic Fatigue
C	**R**	HEAD EYES EAR NOSE THROAT
		Headaches
		Migraines
		Dizziness
		Vision problems
		Ear problems
		Loss of smell
		Dry throat
		Sore throat
C	**R**	RESPIRATORY
		Cough
		Shortness of breath
		Bronchitis
		Emphysema
		Pneumonia
		Asthma & Wheezing

C	R	CARDIOVASCULAR
		Pacemaker
		High blood pressure
		Low blood pressure
		Heart attack/ Stroke
		Varicose/ Spider veins
		Fainting
		Hemophilia
C	**R**	GASTROINTESTINAL
		Ulcers
		Constipation
		Diarrhea
		Irritable Bowel Syndrome
		Crohn's/ Ulcerative Colitis
		Nausea
		Gallstones/ cholecystitis
C	**R**	DERMATOLOGICAL
		Itching
		Rashes
		Eczema
		Psoriasis
		Plantar warts
		Sensitive skin
		Bruise easily
		Dry skin/ scalp

GYNECOLOGICAL

Currently pregnant ☐

How many months

# of pregnancies _____

First Period year

Menopause year

Final period year

Menses duration _____

Cycle duration _____

C	R	
		PMS
		Irregular periods
		Painful periods
		Light periods
		Heavy periods
		Spotting between periods
		Fibroids
		Endometriosis
		Infertility
		Low sexual drive
		High sexual drive

C	R	ANDROLOGICAL
		Difficult ejaculation
		Painful ejaculation
		Premature ejaculation
		Involuntary seminal emission
		Low sexual drive
		High sexual drive
C	**R**	URINARY
		Difficult urination
		Painful urination
		Frequent urination
		Kidney stones
		Kidney disease
		Urinary tract infection (UTI)
C	**R**	PSYCHOLOGICAL & NEUROLOGICAL
		Anxiety
		Depression
		Poor sleep
		High stress level
		Low stress level
		Seizures
		Transient Ischemic Attack (TIA)
		Epilepsy
C	**R**	OTHER
		Loss of sensation
		Loss of balance
		Edema / Swelling
		Cancer (Past or Present)
		Hepatitis
		Sensitivities
		Diabetes
		Tuberculosis
		HIV
		STD/ STI
		Surgical implants
		Pins, Wires, Plates
		Electronic Medical Devices (EMD)
		Prostheses

OTHER

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