Taking Care of Me
Acupuncture Health and 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 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

Medications & 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 and how often/how much

Coffee

Tea

Alcohol

Soda

Tobacco

Other

Sports, Physical Activity and how often

Energy Level (from 1 to 10)

Do you feel (please mark on the scale)

Cold — Hot

PLEASE CHECK OR FILL IN ALL THAT APPLY. (C) for "Chronic" and (R) for "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.

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

HEAD EYES EAR NOSE & THROAT

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Dizziness
- ☐ ☐ Vision problems
- ☐ ☐ Ear problems
- ☐ ☐ Loss of smell
- ☐ ☐ Dry Throat Sore
- ☐ ☐ Throat

RESPIRATORY

- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Asthma and Wheezing

CARDIOVASCULAR

- ☐ ☐ Pacemaker
- ☐ ☐ High Blood pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Heart attack / Stroke / CVA
- ☐ ☐ Varicose / Spider veins
- ☐ ☐ Fainting
- ☐ ☐ Hemophilia

GASTROINTESTINAL

- ☐ ☐ Ulcers
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Crohn's or Ulcerative Colitis
- ☐ ☐ Nausea
- ☐ ☐ Gallstones / Cholecystitis

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_____

- ☐ ☐ PMS
- ☐ ☐ Irregular periods
- ☐ ☐ Painful periods
- ☐ ☐ Light periods
- ☐ ☐ Heavy periods
- ☐ ☐ Fibroids
- ☐ ☐ Endometriosis
- ☐ ☐ Infertility
- ☐ ☐ Low sexual drive
- ☐ ☐ High sexual drive

ANDROLOGICAL

- ☐ ☐ Difficult ejaculation
- ☐ ☐ Painful ejaculation
- ☐ ☐ Premature ejaculation
- ☐ ☐ Involuntary seminal emission
- ☐ ☐ Low sexual drive
- ☐ ☐ High sexual drive

URINARY

- ☐ ☐ Difficult urination
- ☐ ☐ Painful urination
- ☐ ☐ Frequent urination
- ☐ ☐ Kidney stones
- ☐ ☐ Kidney disease
- ☐ ☐ Urinary tract infection (UTI)

PSYCOLOGICAL & NEUROLOGICAL

- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Poor Sleep
- ☐ ☐ High Stress level
- ☐ ☐ Low Stress Level
- ☐ ☐ Seizures
- ☐ ☐ Transient Ischemic Attack (TIA)
- ☐ ☐ Epilepsy

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

Others

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