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Main Health Concerns & Medical History

Please complete the information below, use your PDF viewer's pen tool to mark multiple selections

What is/are your main concerns?

Have you previously tried/ used Acupuncture / TCM to treat your concern (s) ?

☐ Yes ☐ No

Did you find it beneficial / helped your condition?

☐ Yes ☐ No ☐ Somewhat

What other treatment modalities have you tried for this concern?

Select all that apply
Chiropractic
Homeopathy
Low Level Laser
Massage Therapy
Naturopathic
Osteopathy
Physiotherapy
Prescription from FAmily Physician

Other(s):

Pain & Anatomy

If you are having pain, please describe it as best as you can:

What is the INTENSITY of the pain? (1 = least, 10 = highest)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

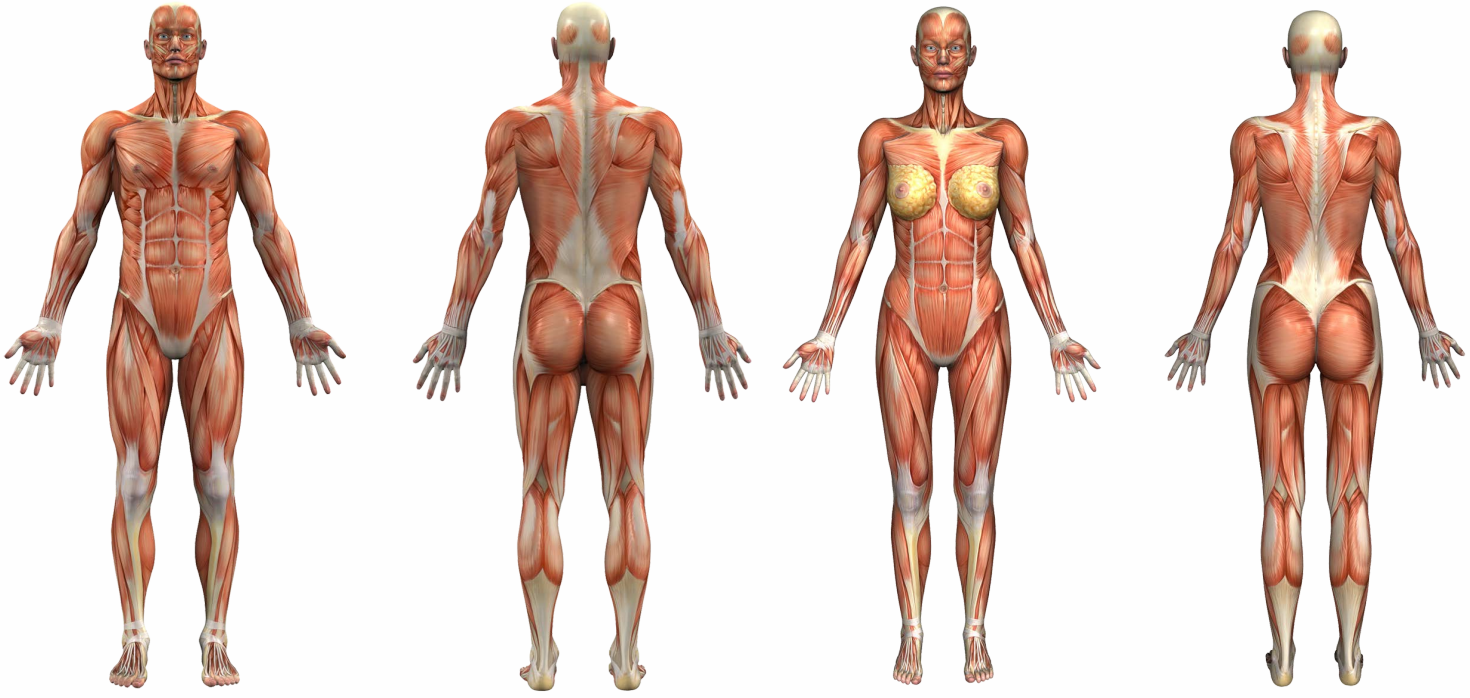
Describe the **type** of pain:

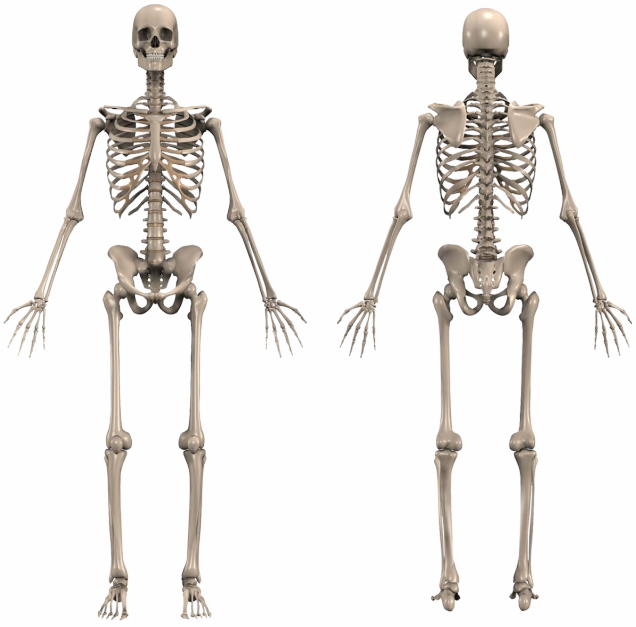
Select all that apply
Burning Pain
Dull Pain
Moving Pain
Radiating Pain
Stabbing Pain

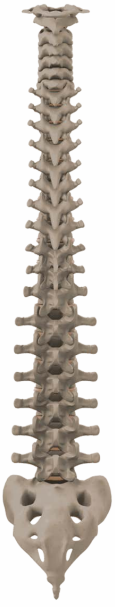
Describe the **Pattern** of the Pain:

Select all that apply
agrivated with activity
comes and goes
Constant
worse at night
worse during the day

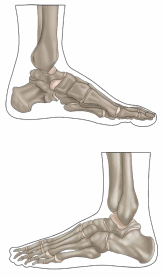
Anything esle you would like to share about the pain?

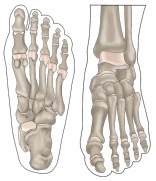




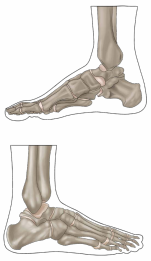


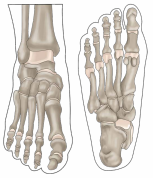
Spine





Left Foot





Right Foot

Medical History

Please select all that are applicable, multiple options may be selected as applies to you.

Head & Neck

Select all that apply
Blurry Vision
Headaches
Hearing Loss
Migraines
Tinnitis
Vertigo
Vision Loss

Respiratory

Select all that apply
Asthma
Bronchitis
Chronic Cough
Chronic Fatigue
Covid 19 (previous)
Emphesyma
Frequent Cold / Flu
Shortness of Breath
Sinusitis
Smoke Cigarettes
Smoke Drugs

Nervous System

Select all that apply
Muslitple Sclerosis
Numbness
Parkinsons / Myoclonus
Sciatica
Seizures
Tingling
Tremors

Muscle-skeletal

Select all that apply
Arthritis
Bursitis
Joint Replacement(s)
Osteoporosis
Previous Motor Vehicle Accident
Previous Slip & Fall Injury
Previous Workplace Injury
Tendonitis
Torn Tendon / Ligament

Allergies

Select all that apply
Allergy to Medications
Animal / pet allergies
Environmental (grass, trees etc.)
Food Allergies (specify)
Insect Allergies
Latex Allergy

Cardiovascular

Select all that apply
Congestive Heart Failure
Heart Attack (previous)
Heart Disease
High blood Pressure
Low Blood Pressure
Pacemaker
Stroke

Reproductive

Select all that apply
Fertility Problems
Gynecological Problems (specify
Menstrual Problems
Cysts / Fibroids
Erectile Difficulty
Low Sperm Count / Mobility
Low Libido

Chronic Conditions

Select all that apply
Anxiety
Cancer (specify)
Chronis Fatigue
Constipation
Crohn's Disease
Depression
Diabetes Type 1
Diabetes Type 2 (non Insulin)
Diabetes Type 2 (w/ Insulin)
Diverticulitis
Hepatitis
HIV /AIDS
Irregular Bowels
Irritable bowel Syndrome (IBS)
Lyme Disease
Psychological Disorders (specify)
Stress
Tuberculosis
unexpected weightloss

OTHER-Specify

Are You Pregnant ? ☐ Yes ☐ No ☐ Possibly / Unsure Due Date:

Medications List : Please list any medications you are currently taking.

DONE

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