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Client Id Number: _____

## New Patient Form - Adult

Date: _____/_____/_____

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential.

Name: _____ Date of Birth: _____/_____/_____

Address: _____ Postcode: _____

Mobile phone: _____ Age: _____ Sex: _____

Email: _____

Weight: _____ Height: _____ Occupation: _____

Marital status: _____ No. and age of children: _____

Family physician: _____ Contact phone: _____

Emergency contact/relationship: _____ Contact phone: _____

How did you find out about me: _____

Have you had acupuncture before: _____ Health Fund: _____

**Presenting Problem(s)**

Main problem you are seeking treatment for: _____

_____

_____

Please describe your symptoms: _____

_____

_____

_____

_____

_____

When did this problem begin: _____

What seems to be the original cause: _____

_____

Have you been given a diagnosis for this problem: _____

_____

Do you have any recent (<2 years) lab reports/scans related to this problem (If yes, please attach to this form): _____

Are you currently receiving treatment for this: _____

_____

What other therapies have you tried for this problem: _____

_____

Does this problem interfere with □work □sleep □sport □other (describe): _____

_____

What was your state of health like at the onset of this problem: _____

_____

Please list any prescribed medications you are taking (include dosage): _____

_____

Please list any non-prescribed medication you are taking (include dosage): _____

_____

Please list any other remedies you are taking (herbs, vitamins, minerals, etc): _____

_____

_____

**Personal Medical history**

☐Cancer _____ ☐Diabetes_____ ☐Hepatitis _____ ☐High/Low Blood Pressure _____
☐Heart Disease _____ ☐Pacemaker _____ ☐Stroke _____ ☐Rheumatic Fever _____
☐Blood transfusion _____ ☐Thyroid Disease _____ ☐Seizures _____ ☐STD _____
☐Asthma/wheezing _____ ☐Parasite infection _____ ☐Prolapse _____ ☐Hernia _____
☐Migraines _____ ☐Bloodclotting problems _____ ☐Mental Illness _____
☐Skin cancer _____ ☐other _____

Childhood illness/conditions: _____

_____

Surgeries (year/type): _____

_____

_____

Significant trauma - year/type (car accidents, falls, emotional, broken bones, etc.): _____

_____

_____

Significant dental work (last 2 yrs - year/type): _____
Your birth history (prolonged labour, premature, forceps delivery, etc.): _____

_____

Allergies (drugs, chemicals, foods, etc. and reaction): _____

_____

**Family medical history**

☐Diabetes ☐Cancer ☐High blood pressure ☐Heart disease ☐Stroke ☐Seizures ☐Asthma ☐Allergies ☐Mental Illness
☐Thyroid Disease ☐Migraines ☐Kidney disease ☐Arthritis ☐Anaemia ☐other: _____

**Diet/Lifestyle/Environment**

In a typical day, what do you normally eat?
Morning: _____
Lunch: _____
Evening: _____
Snacks (what/time of day): _____
Amount you drink per week: coffee _____ tea _____ softdrink _____ alcohol _____ water _____ juice _____
What flavour do you crave/avoid? (Sweet, salty, pungent/spicy, sour, bitter) _____
Do you exercise? _____ What/how often per week? _____
Do you practice/how often per week ☐meditation ☐relaxation technique ☐prayer _____

Any recent (past 2 years) ☐pest control ☐renovations ☐major building work: _____

_____

Any recent vaccinations (type/date) (past 2 years): _____

_____

Occupational exposures/stress (chemical, physical, psychological, etc.): _____

_____

Amount of the following in the past 5 years: ☐x-rays _____ ☐scans _____ ☐ultrasounds _____

Do you smoke and/or use recreational drugs? What and how much per week: _____

_____

**Please check any symptoms that have been persistent in the last 3-6 months**

**General**

☐chills ☐fevers ☐night sweats ☐localized weakness ☐poor sleeping ☐bruise easily ☐strong thirst ☐fatigue ☐oedema ☐sudden drop in energy ☐tremors ☐poor balance ☐cravings ☐change in appetite ☐weight loss/gain _____

_____

**Skin and hair**

☐rashes ☐itching ☐ulcerations ☐changes in hair/skin ☐hives ☐eczema ☐pimples ☐recent moles ☐skin cancer ☐hair loss ☐dandruff_____

**Head, eyes, ears, nose and throat**

☐dizziness ☐facial pain ☐migraines ☐headaches ☐glasses/contact lenses ☐night blindness ☐blurry vision ☐eye pain ☐dry eyes ☐cataracts ☐spots in vision ☐tearing ☐poor hearing ☐ringing in ears ☐earaches ☐nose bleeds ☐sinus congestion ☐sinus/nasal discharge ☐teeth grinding ☐jaw clicks ☐sore throats ☐sores on lips ☐mouth sores

_____

**Cardiovascular**

☐chest discomfort/pain ☐heart palpitations ☐cold hands/feet ☐fainting ☐swelling of hands/feet ☐difficulty breathing

_____

**Respiratory**

☐cough ☐pain with deep breath ☐coughing blood ☐pneumonia ☐bronchitis ☐production of phlegm/colour_____

☐frequent colds/flus _____

**Gastrointestinal**

☐bad breath ☐nausea ☐vomiting ☐heartburn ☐belching ☐wind ☐indigestion ☐diarrhoea ☐constipation ☐blood in stool ☐black stool ☐abdominal pain/cramps ☐rectal pain ☐haemorrhoids ☐ulcer _____

_____

**Pregnancy and gynaecology**

No. of pregnancies _____ no. of births _____ no. of miscarriages _____ no. of abortions _____

age at first period _____ length of cycle: _____ length of bleed: _____

date of last period _____ Flow :☐heavy ☐medium ☐light ☐red ☐black ☐purple ☐brown ☐pale ☐dark

☐ pain ☐ clotting ☐ endometriosis ☐other uterine bleeding ☐ pain at ovulation ☐vaginal discharge at ovulation ☐other vaginal discharge ☐breast lumps ☐nipple discharge ☐other _____

_____

last pap smear_____/_____/_____ ☐abnormal pap smear _____ ☐birth control _____

☐menopause: age _____ year _____ ☐HRT/Other: _____

**Genito-urinary**

☐pain on urination ☐urgency to urinate ☐frequent/decreased urination ☐blood in urine ☐unable to hold urination ☐dribbling ☐waking to urinate ☐kidney stones ☐genital sores ☐prostate trouble ☐impotency _____

_____

**Neuropsychological**

☐seizures ☐areas of numbness ☐weakness ☐sleep disorder ☐concussion ☐bad temper ☐vertigo ☐loss of balance ☐loss of control/violent ☐lack of coordination ☐depression ☐mood changes ☐poor memory ☐anxiety ☐substance abuse ☐treated for psychological/emotional disorders_____

_____

**Musculoskeletal**

☐scalp tension ☐neck pain ☐shoulder pain ☐back pain ☐elbow pain ☐hand/wrist pain ☐hip pain ☐knee pain ☐leg pain ☐foot/ankle pain ☐general muscle pain ☐muscle weakness_____

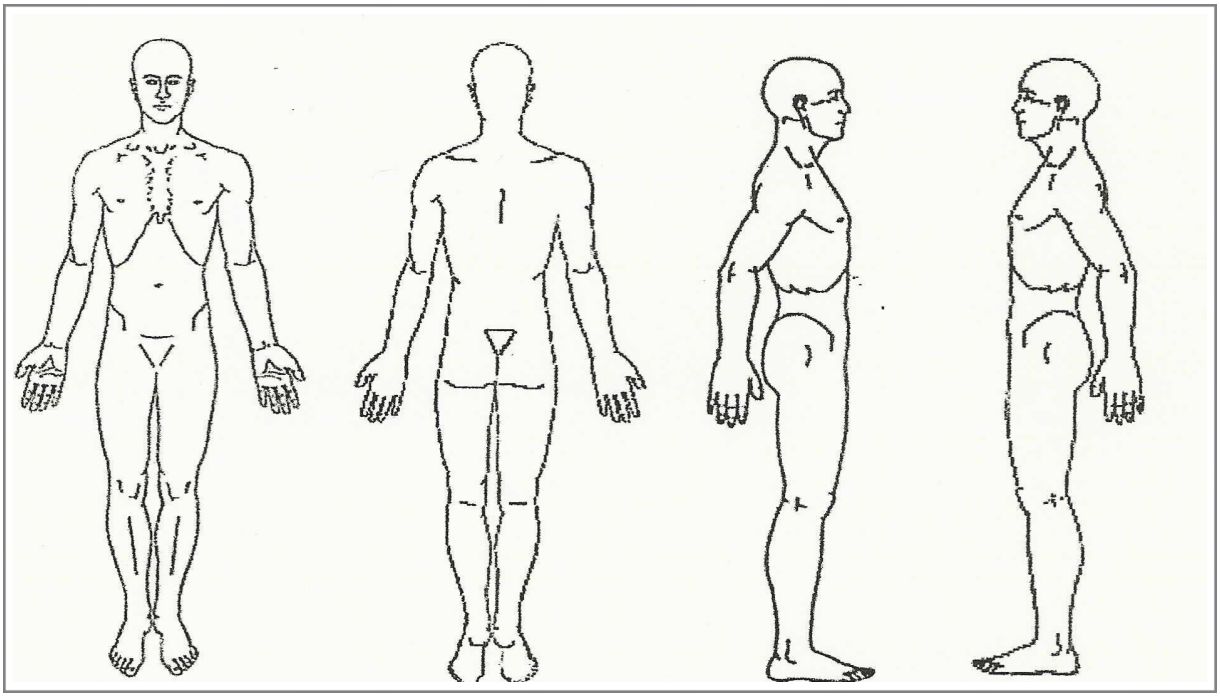
_____

If any of the following apply, please mark on the diagrams below: - **P** - pain, **N** - numbness, **T** - tightness, **X** – tingling

Please list all scars with an **S** on the diagrams below and the date(s) on the following lines:

_____

_____



Please list any additional information that would help me better understand your condition _____

_____

_____

_____

I understand that by signing this form that the information provided is true to the best of my knowledge. I consent to receive the proposed treatments by the attending practitioner, subsequent to discussing the benefit to my health and other Modality treatment options.

Signature: _____ (Guardian) Date: _____

**Please be aware this clinic has a full fee cancellation policy.**

For all consultations **24 hours notice is required** at all times otherwise the full consultation fee will be charged.