Acupuncture New Patient Form

Information collected is confidential and will not be shared with any third parties.

Name:		
Address:		
City:	Prov:	Postal Code:
Home Phone:	Mobile:	
Email:		
Date of Birth:	Gender: Male Female	
Occupation:		
Emergency Contact:	Phone:	
Extended Health Insurance Company:	Policy #	ID #
How did you hear of us?		
Major complaint / Health problem…		
Description	*How long has this been an issue?*	
Please list any medications or supplements you are currently taking…		
Medication/Supplement	*Dose*	*For how long*	*Reason*
Please list any allergies to medication, herbs or food:		
Please list any major surgeries, accidents or illnesses…		
Description	*Date*	

Women Only	**Women Only (Continued)**	**Men Only**
☐Abnormal pap smear ☐Bleed between periods ☐Irregular periods ☐Heavy periods ☐< 25 day cycle ☐>35 day cycle ☐Endometriosis ☐Painful periods ☐Premenstrual tension ☐Breast lumps ☐Contraceptives	☐Low sexual energy ☐Yeast infections often ☐Urinary tract infections often ☐Vaginal discharges ☐Menopausal ☐Uterine prolapse ☐Facial hair ☐Loss of head hair ☐May be pregnant number of pregnancies? complications during or after?	☐Genital pain ☐Impotence ☐Lump in testicles ☐Penis discharge ☐Nocturnal emission ☐Low Sexual energy

Significant Illnesses (Please check all that apply)				
☐ Arthritis	☐ Cancer/Tumour	☐ Genetic Disease	☐ Kidney Stones	☐ Other:
☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Pacemaker	
☐ Autoimmune	☐ Depression	☐ Hepatitis	☐ Seizures	
☐ AIDS/HIV	☐ Gallstones	☐ Hypertension	☐ Thyroid disease	

Please check any symptoms you currently have or have had in the past year.

General
☐Chills
☐Low energy
☐Dizziness
☐Allergies
☐Fatigue
☐Fevers
☐Excess thirst
☐Insomnia
☐Nervousness
☐Numbness
☐Sweat spontaneously
☐Night sweating
☐Lack of sweating
☐Weight loss
☐Weight gain
☐Aversion to heat
☐Aversion to cold

Head & Neck
☐Blurred Vision
☐Heaviness in the head
☐Phlegm in throat
☐Cataract
☐Double Vision
☐Earache
☐Ear discharge
☐Eye pain/strain
☐Corrected vision
☐Nasal obstruction
☐Nasal discharge
☐Loss of sense of smell
☐Hearing loss
☐Hoarseness
☐Nosebleeds
☐Recurrent sore throat ☐ Red/inflamed eye
☐Ringing in the ears
☐Sinus problems
☐Sores on lips
☐Sores on tongue
☐Taste change
☐Teeth problems
☐Vision- see halos
☐Vision-see spots/floaters

Respiratory
☐Asthma
☐Hay fever
☐Persistent cough
☐Coughing blood
☐Shortness of breath
☐Recurrent bronchitis
☐Phlegm production
☐Difficulty inhaling
☐Difficulty exhaling

Cardiovascular
☐Chest pain
☐High blood pressure
☐Low blood pressure
☐Irregular heart beat
☐Poor circulation
☐Swelling of ankles
☐Varicose veins
☐Hypocondriac pain
☐Distention in chest or hypochondrium

Gastrointestinal
☐Abdominal pain
☐Bloating
☐Belching Gas
☐Constipation
☐Diarrhea/loose stool
☐Bloody stool
☐Black stool
☐Difficulty swallowing
☐Poor appetite
☐Heartburn/reflux
☐Hemorrhoids
☐Indigestion
☐Stomachache
☐Nausea
☐Vomiting
☐Vomiting blood

Weight
☐Underweight
☐Normal for height
☐Overweight
☐Very overweight

Diet/Lifestyle
☐Vegetarian
☐Healthy diet
☐Crave fried food
☐Crave red meat
☐Crave sweets
☐Crave salty food
☐Drink alcohol
☐Drink coffee
☐Smoke cigarettes
☐Use drugs
☐Take melatonin
☐Take Steroids
☐Exercise regularly
☐Exercise excessively

Musculoskeletal
Pain, weakness, numbness in:
☐Arms
☐Feet
☐Hands
☐Joints
☐Legs
☐Hips
☐Neck
☐Shoulders
☐Pain all over
☐Cold limbs
☐Knee problems
☐Low back pain
☐All over weakness
☐Lack of strength
☐Broken bones

Neurologic
☐Fainting
☐Convulsions
☐Handwriting change
☐Paralysis
☐Stroke
☐Seizures
☐Tremor
☐Recent clumsiness
☐Drowsiness
☐Vertigo

Skin
☐Thick skin
☐Thin skin
☐Broken blood vessels
☐Blood not clotting
☐Bruise easily
☐Discoloration
☐Dark circles around eyes
☐Bags under eyes
☐Lumps in groin
☐Lumps underarm
☐Dry skin
☐Acne
☐Brittle nails
☐Premature gray hair
☐Dry brittle hair
☐Hair falling out

Emotional
☐Insomnia
☐Irritability
☐Often feel angry
☐Troubling dreams
☐Cry uncontrollably
☐Feel sad a lot
☐Forgetful
☐Mind not clear
☐Anxiety
☐Much fear
☐Unrestrained joy
☐Terrors
☐Difficulty expressing

Genitourinary
☐Dilute urine
☐Dark urine
☐Blood in urine
☐Cloudy urine
☐Burning sensation
☐Scanty urine
☐Profuse urine
☐Frequent urination
☐Poor bladder control
☐Urgency to urinate