Confidential Patient Health Record

Date:

Note: Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Personal Health History						
Preferred Name:				Pronouns:		
Address:				**Phone:**		
City:				**Alternate Phone:**		
Province:		Postal Code:		E-mail:		
Date of Birth:	M	D	Y	Age:	Current Gender Identity:	Weight:
Relationship Status: *Single Married Partnered Separated Divorced Widowed*				Type of Work:		
Emergency Contact:				**Emergency Contact #:**		
Who may we thank for your referral? (How did you hear about us?)						
☐ Yes, I would like to receive emails, including appointment reminders and receipts ☐ No emails ever.						

Is this your first experience with acupuncture or Chinese Medicine?	☐ Yes ☐ No
Are you currently pregnant?	☐ Yes ☐ No
Are you presently trying to get pregnant?	☐ Yes ☐ No

What do you want treated with acupuncture? *(primary complaint, symptom)*
How long have you had this condition? Onset: ☐ Sudden ☐ Gradual
How often do you have this symptom?
What medical diagnosis have you received for this condition (if any)?
Symptoms relieved by:
Symptoms worsened by:
What other treatments have you received for this condition?
What prescription or over-the-counter medications or supplements are you

taking?

Family Medical History

Please list any significant blood relative illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis, etc.

Father:	Mother:
Siblings:	Grandparents:

Past Medical History

☐ HIV	☐ Fibromyalgia	☐ Multiple Sclerosis
☐ Tuberculosis	☐ Heart Disease	☐ Polio
☐ Hepatitis A/B/C	☐ Pacemaker	☐ Sinus Infections
☐ Asthma	☐ Rheumatic Fever	☐ Alcoholism
☐ Emphysema	☐ Scarlet Fever	☐ Drug Addictions
☐ Diabetes, Type:	☐ Herpes/STI	☐ Allergies:
☐ Epilepsy/Seizures	☐ Autoimmune Condition/s	
☐ Anemia	☐ Arthritis	☐ Cancer:
☐ Hypothyroid	☐ Mumps/Measles/Chicken Pox	☐ Surgeries:
☐ Hyperthyroid	☐ Whooping Cough	

Current Health Professionals

I am currently seeing: (check all that apply)

☐ Family Medical Doctor	Name:	Clinic:
☐ Chiropractor	Name:	Clinic:
☐ Massage Therapist	Name:	Clinic:
☐ Physiotherapist	Name:	Clinic:
☐ Naturopathic Doctor	Name:	Clinic:
☐ Dentist	Name:	Clinic:
☐ Acupuncturist	Name:	Clinic:
☐ Personal Trainer	Name:	Gym:
☐ Other: _____	Name:	Clinic:

Exercise & Energy

How is your energy?	☐ Exhausted ☐ Low ☐ Below Normal for me ☐ Average ☐ Good/High
What time of day is your energy: Highest?	☐ Mornings ☐ Noon ☐ Afternoon ☐ Early Evening ☐ Evening/Night
What time of day is your energy: Lowest?	☐ Mornings ☐ Noon ☐ Afternoon ☐ Early Evening ☐ Evening/Night
Do you fatigue easily?	☐ Yes ☐ No

How often do you exercise?	☐ 4-7/week ☐ 2-3/week ☐ 1/week ☐ 1-4/month ☐ Rarely/never
What kind of exercise do you do regularly?	

Emotions & Sleep

How do you feel emotionally?	
How do you hold/handle your stress?	
How do you feel generally about your work and home life?	
How long do you normally sleep?	☐ Less than 4 hrs ☐ 4-6 hrs ☐ 6-7 hrs ☐ 7-9 hrs ☐ 9 hrs or more

Do you have: (check all that apply)

☐ Panic attacks	☐ Depression	☐ Anxiety	☐ Irritability
☐ Bad temper	☐ Mood Swings	☐ Poor memory	☐ Difficult concentration

Do you have difficulties with: (check all that apply)

☐ Falling asleep	☐ Staying asleep	☐ Dream-disturbed sleep	☐ Nightmares
☐ Waking up at night	☐ Waking up multiple times	☐ Can't fall back asleep	☐ Wake up not rested

Gastrointestinal Symptoms

Do you have: (check all that apply)

☐ Belching	☐ Nausea	☐ Vomiting	☐ Vomiting of blood
☐ Ulcers	☐ Bloating	☐ Heartburn/acid reflux	☐ Crohn's/Celiac Disease
☐ Hernia	☐ Indigestion	☐ Severe Abdominal pain	☐ IBS/Colitis/Diverticulitis

Bowel Movements

How often do you have a bowel movement? / day or / week

Do you have: (check all that apply)

☐ Constipation	☐ Diarrhea	☐ Gas	☐ Irregular bowel movements
☐ Burning sensation	☐ Hemorrhoids	☐ Itchiness after BM	☐ Undigested food in stool
☐ Loose stools	☐ Hard stools	☐ Blood in stool	☐ Painful bowel movements
☐ Very smelly stools	☐ White mucus in stools	☐ Abdominal cramping	☐ Intestinal sounds

Urinary Symptoms

How often do you urinate? / day

Quality/Colour of Urine: ☐ Pale yellow ☐ Dark yellow/orange ☐ Bubbles ☐ Cloudy

Do you have: (check all that apply)

☐ Trouble starting stream	☐ Frequent urination	☐ Blood in urine	☐ Urinary tract infections
☐ Pain urinating	☐ Burning	☐ Dribbling urine	☐ White/yellow mucus in urine
☐ Kidney stones	☐ Occasional Incontinence	☐ Incontinence	☐ Kidney disease

Muscles, Joints & Bones

Do you have: (check all that apply)

☐ Swollen joints	☐ Muscle pain	☐ Tendonitis
☐ Stiff joints	☐ Muscle tension	☐ Fibromyalgia
☐ Bone pain	☐ Muscle cramps	☐ Repetitive Strain Injury
☐ Arthritis/Joint pain	☐ Restless Leg Syndrome	☐ Fracture
		Bone:_____

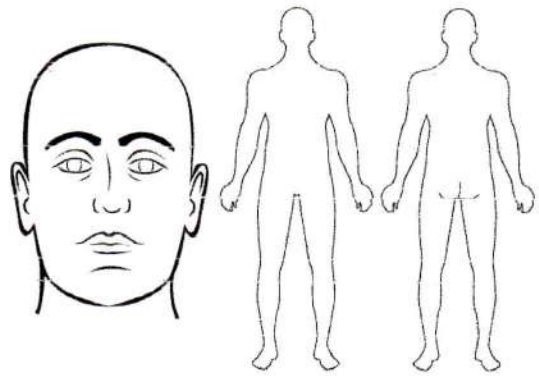
Describe the pain/tension: (check all that apply)

☐ Sharp	☐ Dull	☐ Superficial	☐ Deep

☐ Numbness ☐ Tingling ☐ Burning ☐ Squeezing
☐ Aching ☐ Stabbing ☐ Shooting

Applying heat makes the symptom: ☐ Better ☐ Worse ☐ No difference
Applying cold/ice makes the symptom: ☐ Better ☐ Worse ☐ No difference
Applying pressure makes the symptom: ☐ Better ☐ Worse ☐ No difference

Please use the diagram provided to indicate areas of pain or concern.



Eyes, Ears, Nose, Throat, & Head

Do you have: (check all that apply)

☐ Frequent colds/flu ☐ Chronic runny nose ☐ Frequent sore throat
☐ Chronic cough ☐ Coughing blood ☐ Cough up mucous
☐ Pain on inhaling ☐ Asthma ☐ Nose bleeds
☐ Painful/red eyes ☐ Poor vision ☐ Spots/floaters
☐ Dizziness ☐ Cold sores ☐ Bleeding gums
☐ Dry mouth ☐ Ear pain ☐ Ringing in ears
☐ Clogged/popping in ears ☐ Jaw/TMJ pain
☐ Headaches ☐ Migraines:
Where? ☐ Front/forehead ☐ Top of head ☐ Sides/Temples ☐ Back/occipital/neck ☐ Behind eye(s)
How often do you get a headache? ☐ 1-2/year ☐ 3-11/year ☐ 1/month ☐ 2-4/month ☐ 1-2/week ☐ More than 2/week
How long does a bad headache last without medication? ☐ Minutes ☐ 1-4 Hours ☐ 4-12 hours ☐ 12-24 hours ☐ 2+ Days

Skin & Hair

Do you have: (check all that apply)

☐ Dry skin ☐ Skin rashes ☐ Itching ☐ Bruise easily
☐ Eczema ☐ Hives ☐ Hair loss ☐ Premature greying
☐ Oily skin ☐ Facial pimples ☐ Facial acne ☐ Body acne

Heart & Lungs

Do you have: (check all that apply)

☐ Chest/lung pain ☐ Palpitations ☐ Irregular heart beat
☐ Asthma ☐ Cold hands and feet ☐ Hypertension
☐ Emphysema/COPD ☐ Ankle/leg swelling ☐ Hypotension
☐ Previous Heart attack #_____ ☐ Shortness of breath on exertion ☐ Varicose veins
☐ Angina/Heart disease ☐ Shortness of breath at rest ☐ Poor circulation

Do you smoke? ☐ Yes ☐ No ☐ I used to
How many cigarettes/day now? _____
How many years? _____

Do you want to quit smoking? ☐ Yes ☐ No
When did you start? (age/year) _____
When did you quit? (age/year) _____

Temperature/Sensation

Do you have: (check all that apply)

☐ Feel cold all the time	☐ Feel cold often	☐ Cold feet or hands	☐ Dislike dry air
☐ Feel hot all the time	☐ Feel hot often	☐ Hot feet or hands at night	☐ Dislike humidity
☐ Feel better in cold weather	☐ Feel better in hot weather	☐ Feel better in dry weather	☐ Feel better in humid weather
☐ Feel worse in cold weather	☐ Feel worse in hot weather	☐ Feel worse in dry weather	☐ Feel worse in humid weather
☐ Feel worse in winter	☐ Feel worse in summer	☐ Feel worse in spring	☐ Feel worse in autumn
☐ Dislike wind			

Reproductive Health

Do you have: (check all that apply)

☐ Prostate issue	☐ Erectile dysfunction	☐ Infertility problem	☐ Testicular/Prostate Cancer
☐ Night sweats	☐ Profuse sweating	☐ Other cancer	☐ Mood swings/angry outbursts

Do you have: (check all that apply)

☐ Menstrual cramps/pain	☐ Late/missed periods	☐ Early/frequent periods	☐ Mid-cycle spotting
☐ PCOS/Ovarian Cysts	☐ Vaginal itching/discharge	☐ PMS symptoms	☐ PMS/Menopause headaches
☐ Uterine fibroids	☐ Vaginal dryness	☐ Day sweats	☐ Breast problem
☐ Menopausal symptoms	☐ Hot flashes	☐ Night sweats	☐ Breast cancer
☐ Hysterectomy	☐ Endometriosis	☐ Recurrent yeast infection	☐ Ovarian/Cervical/Uterine cancer
☐ Tender breasts	☐ Fibrocystic breasts	☐ Pain during sex	

Reproductive history:

Menstruation started at age: _____ Menstruation ended at age: _____

☐ Children # _____ ☐ Pregnancies # _____ ☐ Abortions # _____ ☐ Miscarriages # _____

Menstruation: (check all that apply)

Blood colours: ☐ bright red ☐ dark red ☐ pale/pink ☐ blackish ☐ purple ☐ brown

Clotting: ☐ no clots ☐ some small clots ☐ some large clots ☐ dark clots ☐ red clots ☐ dilute/watery

Flow: ☐ heavy ☐ very heavy ☐ very light ☐ light

Days of flow: ☐ none ☐ 1-3 days ☐ 4-6 days ☐ 7 or more days

Menstrual Pain: ☐ before flow ☐ first day ☐ during period, any day ☐ after period ☐ on ovulation (two weeks)

Fertility:

☐ I am trying to conceive ☐ I am not trying to get pregnant, but could become pregnant during the course of treatments.

Please tell me what you have done in the past and what you are doing currently to try to conceive a child:

Informed Consent for Acupuncture Care

Please read carefully and sign or initial where indicated.

I hereby request and agree to the performance of acupuncture With Tonya Coutts Wirth RAc. Dr. Ac Dip TCM and other procedures related to acupuncture if necessary, including needling, moxibustion, cupping, gua sha, laser acupuncture, electro-acupuncture, acupressure, ear seed placement and other techniques within the scope of practice of registered acupuncturists. (***Initial***) _____.

I have had the opportunity to discuss the nature and purpose of acupuncture care and other procedures with the registered acupuncturist and/or with other office or clinic personnel. I understand the results are not guaranteed. (***Initial***) _____.

Acupuncture has been shown to benefit and normalize physiological responses in the body. I further understand and am informed that, as in all healthcare, the practice of acupuncture, even though all needles are pre-sterilized and disposable, there are some risks to treatment including but not limited to temporary soreness, dizziness, fatigue, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgement during the course of procedures which the acupuncturist feels at the time, based upon facts then known, in my best interest. I understand and acknowledge withholding or giving false information can lead to improper treatment that the registered acupuncturist cannot be held liable for. ***(Initial)*** _____.

Section 8 (1) of Alberta's Acupuncture Legislation states that a registered acupuncturist shall not undertake the care and treatment of a person unless; (a) that person has already consulted a physician, or in the case of a dental pathology, a dentist, about the condition(s) for which treatment is being sought; (b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition(s) and; (c) that the patient has completed a patient consultation form. (***Initial***) _____.

I understand that the cost associated with acupuncture treatments is NOT covered by Alberta Health and I am fully responsible to the acupuncturist for the entire treatment amount. (***Initial***) _____.

I have read the above consent or have had it read to me. I have also had an opportunity to ask questions about its content; and by signing below I agree to the above named procedure(s). I further intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X _____ X _____

Patient Signature
Parent/ Guardian Signature

Print Name
Relationship to Patient

X _____ X _____

Witness Signature

Date