Your Personal Health History

In our clinic, we focus on your ability to be healthy. Our goals are, first to address the issues that brought you to this office, and second to offer you the opportunity of improved health and wellness in the future. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Last Name: _____ Given Name: _____

Birth Date: _____ Marital Status: _____

Address: _____ Postal Code: _____

Phone: (H)_____ (C)_____ (W)_____

Email: _____ Referred By: _____

Physician: _____ Date of last visit: _____

Occupation: _____ AHC#_____

Main Concern(s):

_____

_____

Health Goals:

_____

_____

When did you first notice your problem: (please be specific)

_____

_____

Does your condition seem to be getting: (please circle)

□Better □Worse □Remains Constant □Comes and goes

Your Health History

1. Please check if you had any of the following in the past year:

   □CT □Scan □MRI □X-Ray □Ultrasound □Blood test □Angiogram

2. Have you had any major or chronic illness in the past?
   _____
   _____

3. Please list any surgery or hospitalizations. What were they for and when did they occur?
4. Please list any medications and nutritional supplements you are currently taking:

Name & Dosage	Prescribed by:
_____	□MD □Other _____
_____	□MD □Other _____
_____	□MD □Other _____
_____	□MD □Other _____

Please check any condition that you have currently (c) or have had in the past (p)

□Alcoholism	□Forgetfulness	□Neuralgia/Neuritis
□Allergies	□Gallstones	□Night Sweats
□Anemia	□Grinding Teeth	□Osteoporosis
□Angina pectoris	□Gum or Teeth Problems	□Palpitations
□Arthritis	□Hay Fever	□Perspire Easily
□Asthma	□Hearing Loss	□Pneumonia
□Back pain	□Heart Attack	□Reduced Sexual Energy
□Bladder Disease	□Heart Disease	□Rheumatic Fever
□Bleeding tendency	□Hemophilia	□Ringing in Ears
□Brittle Nails	□Hemorrhoids	□Sciatica
□Bronchitis	□Hepatitis	□Sexually Transmitted
□Bruise Easily	□High Blood Pressure	Diseases
□Cancer	□HIV Positive	□Sores in Mouth
□Chest Pain	□Hives or Rashes	□Stomach Ulcers
□Cold hands/feet	□Insomnia	□Stroke
□Constipation	□Irritable Bowel Syndrome	□Sudden Drops in Energy
□Depression	□Kidney Disease	□Sudden loss of weight
□Diabetes	□Kidney Stones	□Tension/Anxiety
□Disturbed sleep	□Leukemia	□Thyroid Condition
□Dizziness	□Liver Disease	□Tonsillitis
□Dry Skin	□Loose Bowel	□Tuberculosis
□Eczema	□Low Blood Pressure	□Vision Problems
□Edema	□Low Libido	□Other (please specify)
□Emphysema	□Malaria	
□Epilepsy	□Migraines	
□Eye Infections	□Multiple Sclerosis	

Are you presently being treated by a Medical doctor, Naturopathic doctor and/or Chiropractor?
□Yes □No
By Whom: _____

For which problem:

_____

Are you seeking treatment as a result of a motor vehicle accident (MVA)? □ Yes □ No

If yes, what was the date of accident?

_____

What type of injury did you sustain?

_____

_____

Are you engaged in a lawsuit or any legal action for the MVA? □Yes □No

Are you seeking treatment for a work related injury? □Yes □No

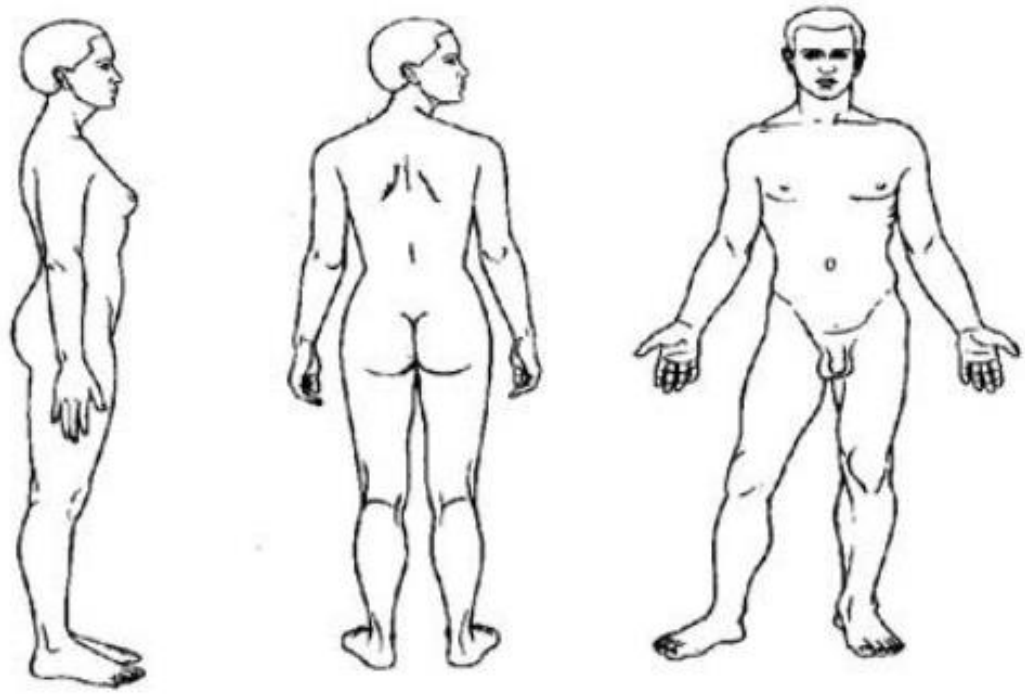
If yes, what type of injury?

_____

Do you have an accident report from your doctor or hospital? □Yes □No

Are you engaged in a Worker Compensation Board (WCB) claim? □Yes □No

Please indicate the pain and discomfort areas on the following figures:



Lifestyle

Please be as honest as possible during this portion of the questionnaire. If you feel uncomfortable answering any of the following, leave it blank and it can be discussed during your assessment.

Remember, all of this information is strictly confidential and can only be released with your written consent.

Please check if you:

Smoke: How many: Per day: _____ Per week: _____ Per Month: _____
Drink: What kind: □Wine □Hard Liquor □Beer How often:_____
Regularly take Painkillers? What kind:_____ How often:_____
Use recreational drugs? What kind:_____ How often:_____

Please rate your current stress level (1=not too much stress, 10=very stressed)

1 2 3 4 5 6 7 8 9 10

How long have you had this stress level? _____

Informed Consent
Please read the entire consent carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including moxabustion, cupping, point injection, electro-acupuncture, Chinese herbals and other techniques within the scope of practice of acupuncturists. These procedures may be performed by Dr. Lisa Baldwin, Registered Acupuncturist and TCMD or Jeanette Davison, Registered Acupuncturist.

I further understand and am informed that in the practice of acupuncture, as in all health care, there are some slight risks to treatment; although all needles are pre-sterilized and disposable. These risks include, but are not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock.

I have read the above consent and understand I have also had an opportunity to ask questions about its content. By signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____ _____

Date (dd/mm/yy) Patient's Signature