DOUGLASDALE
FAMILY CHIROPRACTIC
UNLEASH YOUR FULL POTENTIAL

Acupuncture/Oriental Massage Health Information Sheet

General information

Name: _____ Today's Date: _____
Birthday: (MM) _____ (DD) _____ (YR) _____ Gender: Male_____ Female_____
Home Address: _____ Postal code: _____
Phone #: _____ (Cell) _____ (Home) _____ (Business)
Occupation_____ Email: _____
Emergency Contact (Name) _____ Phone#_____
Family Doctor (Name) _____ Phone#_____
Referred By _____

Health History - Please check symptoms/problems you have had in the past year:

1. **General:**
Chills ( ); Depression( ); Dizziness/Faint( ); Headaches( ); Migraine( ); Fever( ); Forgetfulness( ); Tension( ); Nervousness( ); Numbness( ); Sweats( ); Sleep Deprivation( ); Weight Loss( ); Arthritis( ); Allergies( );
Other_____

2. **Muscle/Joint/Bone having pain, weakness, or numbness in:**
Arms ( ); Elbow ( ); Neck ( ); Shoulders ( ); Upper Back ( ); Lower Back ( ); Hips ( ); Knees ( ); Legs ( )

3. **Cardiovascular:**
Heart Disease ( ); Stroke (TIA) ( ); Anemia ( ); High/Low Blood Pressure ( ); Irregular Heart Beat ( ); Rapid/Slow Heart Rate ( ); Varicose Veins ( ); Poor circulation ( )

4. **Gastrointestinal:**
Poor Appetite ( ); Bloating ( ); Bowel Changes ( ); Constipation ( ); Diarrhea ( ); Excessive Hunger ( ); Excessive Thirst ( ); Gas ( ); Indigestion ( ); Nausea/Vomiting ( ); Stomach Pain ( )

5**. Urinary:**
Frequent Urination ( ); Lack of Bladder Control ( ); Painful Urination ( ); Renal Stone ( )

6. **Eye, Ear, Nose, Throat:**
Blurred vision ( ); Crossed eye ( ); Double vision ( ); Sinus problems ( ); Hay fever ( ); Hoarseness ( ); Persistent cough ( ); Difficulty swallowing ( ); Earaches ( ); Hearing loss ( ); Ringing in Ears ( ); Nosebleeds ( )

7. **Skin:**
Bruise easily ( ); Hives ( ); Itching ( ); Changes in moles ( ); Rash ( ); Eczema ( ); Psoriasis ( )

8. **Reproductive:**
Men only: Erectile difficulties ( ); Prostate problems ( ); other_____
Women only: Breast lump ( ); Menstrual problems ( ); other_____

Please list any illness or surgeries and their dates: _____

Please list any accidents and their dates: _____

Do you have any of the following? Please check the applicable boxes:

AIDS ( )	Arthritis ( )	Asthma ( )	Cancer ( )
Depression ( )	Diabetes ( )	Stroke ( )	Heart Disease ( )
Kidney Disease ( )	Pace Maker ( )	Epilepsy/Seizures ( )	Thyroid Dysfunction ( )
Hepatitis ( )	Metal Implants ( )	High Blood Pressure ( )	

Current history
What brings you in for Acupuncture & Chinese Medicine?

Have you consulted a medical doctor about the condition for which you seek Traditional Chinese Medicine treatment? Yes____ No____

Have you received any Acupuncture treatment in the past (includes Acupuncture & Herbs)? Yes____ No____

If yes, describe what type treatment and medication you have been given (when, where, how long, name of medication, dosage; etc.)

Are you currently taking any kind of Medication or Nutritional Supplement?
If yes please specify:

Name	Dosage per day	Reason for taking

Do you bleed or bruise easily? Y___ N___
Are you on anti-coagulant medication? Y___ N___
Allergies: Y___ N___ Type_____
Pain: Are you experiencing any pain now? Y___ N___ Where_____
How would you rate your pain from a scale of 0 (least) to 10 (severe)? Score_____
Sensation: numbness ( ): where_____; tingling ( ): where_____;
Dizziness ( ): how often_____ when_____

Energy level:
Your energy in general: normal ( ); decreased ( )
Concentration/memory: normal ( ); decreased ( )
Do you feel tired? Always ( ); Sometimes ( )

Hobbies:
Do you smoke? Y___ N___ How many cigarettes per day _____
Do you consume alcohol? How many beverages / week? _____
Other hobbies_____

Are you physically active? Yes____ No____

Emotional state:
Which of the following emotions do you feel often?
sadness ( ); grief ( ); anxiety ( ); worry ( ); irritability ( ); anger ( ); frustration ( ); insecurity ( )

Do you experience or have you experienced any of the following in the past months?
Shortness of breath ( ); Palpitations ( ); Pain or tightness in chest ( );
Swelling ( ) where_____; Skin problems ( ) Describe_____

Missed/Cancelled Appointments: Douglasdale Family Chiropractic has a 24 hour cancellation policy for Acupuncture appointments. **To avoid being charged $30.00 please call 403-279-2229 if you need to reschedule or cancel your Acupuncture appointment within 24 hours of scheduled appointment time.**

I understand that I am receiving a consultation from Dr. Raymond Liu, DTCM, (Doctor of Traditional Chinese Medicine) and that subsequent diagnosis and treatment (which may include acupuncture, acupressure, massage, cupping, moxibustion, Chinese herbs, etc.) are not based upon an Allopathic/Biomedical framework but, rather, according to the logic and criteria prescribed by Traditional Chinese Medicine.
Furthermore it is my desire to receive treatment according to Traditional Chinese Medical Theory and I take full responsibility for the choosing and administering of these therapies.
I understand that I may experience some bruising, soreness or numbness after treatment, and that this is a normal reaction.
I understand that TCM (Traditional Chinese Medicine) is not covered by Health Care and therefore I am responsible to pay all costs incurred per visit. Payment is to be made upon rendering of services.
I am aware that if seeking treatment under an insurance claim I am responsible for the payment of all costs incurred during treatment and will submit receipts or statements received for reimbursement to the insurance company myself.

_____	_____
Name of client (Please print)	Name of Acupuncturist/TCMD
_____	_____
Signature of client	Signature of Acupuncturist/TCMD
_____	_____
Date	Signature of Witness