Patient Information & Health History

Name____ Date______________

Date of Birth (mm/dd/yy)_________________ Age_________ ☐Male ☐Female

Address________________________ City______________ Postal Code_________

Occupation____

Phone (C)______________________ E-mail____

Phone (H)______________________ ☐Married/Common-Law ☐Single ☐Divorced ☐Widowed

Phone (W)______________________ Spouse's name (if married)____________________________

Do you have extended health benefits for acupuncture? ☐Yes ☐No ☐Don't know $ Participation/year? _________

Emergency Contact/Next of Kin:

Name_________________________ Phone___________________ Relationship______________

Major health complaint(s) you would like us to help you with, in order of significance to you:

1. ________________________________ 4. ________________________________

2. ________________________________ 5. ________________________________

3. ________________________________ Additional:____________________________

Medications you are currently taking:

1. ______________________ 2.______________________ 3.______________________

4. ______________________ 5. ______________________ 6.______________________

Supplements (vitamins, minerals, herbs, etc.) you are currently taking:

1. ______________________ 2.______________________ 3.______________________

4. ______________________ 5. ______________________ 6.______________________

How did you hear about our office?____

Have you ever received acupuncture before? ☐No ☐Yes

If yes, how often and for how long? ____

Informed Consent to Acupuncture and Traditional Chinese Medicine Treatment

Avenue Acupuncture
202-1896 Avenue Rd
Toronto, ON, M5M 3Z8
(416) 449-6756

I, the undersigned, understand that acupuncture and other Traditional Chinese Medicine modalities are safe and effective for the prevention and treatment of a wide range of health problems, and for the promotion of general well being. I understand that acupuncture is not a substitute for conventional medical diagnosis and treatment provided by a medical doctor. I am aware that the acupuncturist does not diagnose illnesses or diseases and does not prescribe medications. I am aware that if I want to alter my pharmaceutical regime in any way, I must consult my medical physician before doing so.

I have informed the acupuncturist of all my known physical, emotional, and medical conditions and medications, and I will keep the acupuncturist updated on any changes. If I experience any pain or discomfort during the session, I will immediately communicate that to the acupuncturist so the treatment can be modified.

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following: Some pain following treatment in the insertion area, minor bruising, light-headedness, and fatigue.

I understand that there is neither an implied nor stated guarantee of success of effectiveness of a specific treatment or series of treatments. I understand that certain medications and social habits may decrease the beneficial effects of acupuncture Chinese herbs. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I agree to give 24 hours notice to the clinic if I must cancel or re-schedule an appointment. I understand that I will be charged at current clinical rates when no notice is given or for failing to show up to the appointment. Exceptions may be made in a case of an emergency. I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of present and future care.

Print Name______________________________________

Signature____ Date______________

New Patient Health History Questionnaire

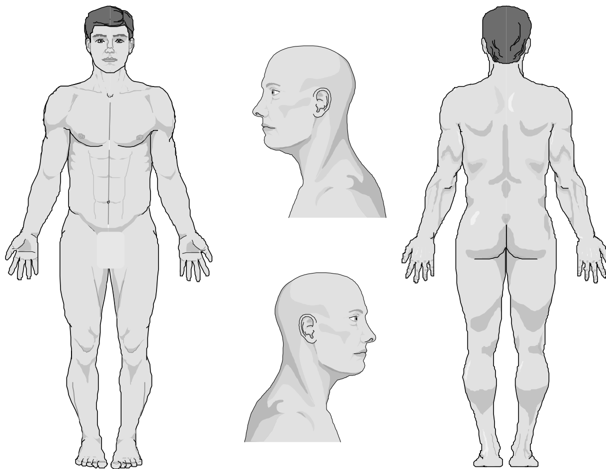
Please indicate if you have (or had) any of the following:							
☐	Diabetes	☐	Allergies	☐	Rheumatic Fever	☐	Vein Condition
☐	Heart Disease	☐	CVA (stroke)	☐	Thyroid Disorder	☐	Tuberculosis
☐	Asthma	☐	Pneumonia	☐	Emphysema	☐	Chicken Pox
☐	High Blood Pressure	☐	Gonnorhea	☐	Bleeding Tendency	☐	Polio
☐	Syphilis	☐	Measles	☐	Nervous Disorder	☐	Migraines
☐	Meningitis	☐	HIV	☐	Mononucleosis	☐	Other Liver Illnesses
☐	Epilepsy	☐	High Fever	☐	Multiple Sclerosis	☐	Other Heart Illnesses
☐	Paralysis	☐	Cancer	☐	Jaundice	☐	Other Kidney Illnesses
☐	Glaucoma	☐	Mumps	☐	Hepatitis	☐	Other Lung Illnesses

SURGERIES?____
____
____

1. Describe your pain:

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other:______________________

On the figures below, please mark clearly any areas of pain.



2. Kidney Function:
(Overall Temperature)

- ☐ Cold Hands
- ☐ Cold Fingers
- ☐ Cold Toes
- ☐ Cold Feet
- ☐ Sweaty Hands
- ☐ Sweaty Feet
- ☐ Hot Body Temperature Sensation
- ☐ Cold Body Temperature Sensation
- ☐ Afternoon Flushes
- ☐ Night Sweats
- ☐ Heat in the hands, feet & chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Take water to bed

3. Lung Function:

- ☐ Nasal Discharge (colour_________)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies (what?________________)
- ☐ Alternating Chills/Fever
- ☐ Sneezing
- ☐ Headache (location_____________)
- ☐ Stiff Neck
- ☐ Sore Throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# per day______)
- ☐ Sadness

New Patient Health History Questionnaire

4. Lung, Kidney Function:
(Overall Energy)

- [ ] Shortness of Breath
- [ ] Difficulty keeping eyes open (daytime)
- [ ] General Weakness
- [ ] Easily catch colds
- [ ] Low Energy
- [ ] Feel worse after exercise
- [ ] Chronic (daily) fatigue & malaise

5. Liver Function (eyes):

- [ ] Itchy
- [ ] Bloodshot
- [ ] Hot
- [ ] Dry
- [ ] Watery
- [ ] Gritty
- [ ] Blurry Vision
- [ ] Decreased Night Vision
- [ ] Near-sighted
- [ ] Far-sighted
- [ ] See Floating Black Spots

6. Bladder Function

Colour (please check):
Pale____; Dk Yellow____; Clear____

- [ ] Reddish
- [ ] Cloudy
- [ ] Scanty
- [ ] Profuse
- [ ] Strong odour
- [ ] Burning
- [ ] Painful
- [ ] Discharge
- [ ] Difficult
- [ ] Urgent
- [ ] Frequent

7. Heart Function:

- [ ] Anxiety
- [ ] Sores on tip of tongue
- [ ] Restlessness
- [ ] Mental confusion
- [ ] Chest pain traveling to shoulder
- [ ] Frequent dreams
- [ ] Wake unrefreshed
- [ ] Trouble falling asleep
- [ ] Wake frequently during night
- [ ] Wake early and cannot return to sleep
- [ ] Coffee? How much per week?_____
- [ ] Dizziness

8. Spleen Function:

- [ ] Low Appetite
- [ ] Abrupt Weight Gain
- [ ] Abrupt Weight Loss
- [ ] Abdominal Bloating
- [ ] Abdominal Gas
- [ ] Gurgling noise in Stomach
- [ ] Fatigue after eating
- [ ] Prolapsed Organ? Which?______
- [ ] Bruise easily?
- [ ] Over-Thinking
- [ ] Worry

9. Spleen, Stomach, Small/Large Intestine Function

- [ ] Loose Stools
- [ ] Constipated
- [ ] Incomplete Stools
- [ ] Diarrhea
- [ ] Blood in Stools
- [ ] Mucous in Stools
- [ ] Undigested food in the Stools

10. Stomach Function:

- [ ] Burning sensation after eating
- [ ] Large appetite
- [ ] Bad Breath
- [ ] Canker Sores (mouth)
- [ ] Bleeding, swollen or painful gums
- [ ] Heartburn
- [ ] Acid Regurgitation
- [ ] Ulcer (diagnosed? Y N)
- [ ] Belching
- [ ] Hiccups
- [ ] Stomach Pain
- [ ] Vomiting

11. Water Retention

- [ ] Bodily sensation of heaviness
- [ ] Mental heaviness
- [ ] Mental sluggishness
- [ ] Mental fogginess
- [ ] Swollen hands
- [ ] Swollen feet
- [ ] Swollen joints
- [ ] Chest congestion
- [ ] Nausea
- [ ] Snoring
- [ ] Overall achy feeling

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New Patient Health History Questionnaire

12. Kidney, Urinary Bladder Function:

- [ ] Frequent cavities, teeth problems
- [ ] Easily broken bones
- [ ] Sore knees
- [ ] Weak knees
- [ ] Cold sensation in the knees
- [ ] Low back pain
- [ ] Memory problems
- [ ] Excessive hair loss
- [ ] Low-pitched ringing in the ears
- [ ] Kidney stones
- [ ] Bladder Infections
- [ ] Lack of bladder control
- [ ] Wake during the night (2 or more) times to urinate?
- [ ] Fear
- [ ] Easily startled
- [ ] Low libido

Women Only:

For the following complaints, check off which applies to your menstrual cycle

	Pre	During	Post
☐ Nausea			
☐ Vomiting			
☐ Food cravings			
☐ Water retention			
☐ Breast swelling			
☐ Breast tenderness			
☐ Headaches			
☐ Migraines			
☐ Dull pain			
☐ Sharp pain			
☐ Depression			
☐ Irritability			
☐ Anxiety			

- [ ] Other (explain___________________)

13. Liver, Gall Bladder Function:

- [ ] Alternating Diarrhea & Constipation
- [ ] Chest Pain
- [ ] Tight sensation in the Chest
- [ ] Bitter taste in the mouth
- [ ] Anger easily
- [ ] Depression
- [ ] Frustration
- [ ] Irritability
- [ ] Skin rashes
- [ ] Headache at the top of the head
- [ ] Tingling sensation
- [ ] Numbness
- [ ] Muscle twitching
- [ ] Muscle cramping
- [ ] Muscle spasms
- [ ] Seizures
- [ ] Convulsions
- [ ] Lump in the throat
- [ ] Neck tension
- [ ] Shoulder tension
- [ ] Limited Range-of-Motion (Neck)
- [ ] Limited Range-of-Motion (Shoulder)
- [ ] Alcohol intake / week?_________
- [ ] Recreational drugs (which?_______)
- [ ] High-pitched Ringing in Ears
- [ ] Gallstones (history or current)
- [ ] STDs (which?_________________)
- [ ] Unable to adapt to Stress
- [ ] High libido

Men Only:

- [ ] Swollen testes
- [ ] Testicular pain
- [ ] Impotence
- [ ] Premature ejaculation
- [ ] Feeling of coldness or
- [ ] Numbness in external genitalia

WOMEN ONLY

☐ Yes	☐ No	Do you have a regular menstrual cycle?	________	Age of first menstruation
☐ Yes	☐ No	Are you pregnant?	________	Average number of days in flow
☐ Yes	☐ No	Do you have bleeding between periods?	________	Average number of days in entire cycle
☐ Yes	☐ No	Do you have vaginal discharge?	________	Number of children
☐ Yes	☐ No	Are you using birth control pills?	________	Number of pregnancies
			________	Age of menopause (if applicable)

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Colour (choose one): pale, bright red, brown rust, dark purple, other							
Amount of flow (choose one): light, medium, heavy							
Clotting (choose one) none, light red, dark red, purple							

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