



## South Calgary Acupuncture Centre

### General Information Case#: \_\_\_\_\_ Date:

Name:                   Gender:       /      

Birth of Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ LBS

Marital Status:  Single  Married  Divorced  Widowed Other: \_\_\_\_\_

Address: \_\_\_\_\_ Post code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (O) \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

In Emergency notify: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who is responsible for your bill?    Self /    Spouse /    Parent Others: \_\_\_\_\_

Insurance other than AHC? (Blue Cross, London Life, etc.): \_\_\_\_\_

How did you find us?

Referred by the other health professionals: \_\_\_\_\_ Internet: \_\_\_\_\_

Family: \_\_\_\_\_ Friends: \_\_\_\_\_ Walk by: \_\_\_\_\_ Others: \_\_\_\_\_

### Current Health Condition

Chief complaints: \_\_\_\_\_

How long have you had it? \_\_\_\_\_ Medical diagnosis: \_\_\_\_\_

What do you believe caused this problem? \_\_\_\_\_

Are there others in your family with this same condition? \_\_\_\_\_

Is this a WCB case?  If yes, Social Insurance #and Date of accident: \_\_\_\_\_

Are you currently wearing an electric device?    Yes /    No

If yes, describe: \_\_\_\_\_

Have you received any alternative health services?

Acupuncture: \_\_\_\_\_ Chinese herbs: \_\_\_\_\_ Chiropractic care: \_\_\_\_\_

Massage: \_\_\_\_\_ Physiotherapy: \_\_\_\_\_ Others: \_\_\_\_\_

Have you consulted with a medical doctor or dentist about concerns?    Yes /    No

Is there any history of injuries or surgery?    Yes /    No

If yes, describe below: \_\_\_\_\_

Are you on any medication? Please indicate name, dosage, frequency and duration of the use of the medication. \_\_\_\_\_

Any supplements: \_\_\_\_\_

Are you on a restricted diet or exercise program? \_\_\_\_\_

Do you have any cravings? Please describe, or circle: like spicy food, coffee, drugs, alcohol, cigarettes: \_\_\_\_\_

### Family Medical History:

Allergies  Diabetes  Hypertension  Hypotension

Asthma  Cancer  Stroke  HT disease

Seizures  Alcoholics  Others: \_\_\_\_\_

### Personal Health History:

Diabetes  Stroke  Birth trauma  Accident/Trauma

Hepatitis  Asthma  Seizures  Alcoholism



- Bleeding disorders
- Cancer/Tumors
- High/low blood pressure
- HIV/AIDS
- Venereal Disease
- Arthritis
- Thyroid Disease
- Allergies (drugs, food, etc)
- HT disease

Still taking medicine for those diseases, please write down their names, dosages: \_\_\_\_\_

Please **CHECK** present symptoms or conditions that are bothering you or required professional help.

**General:**

- Fever/cold
- Nervousness
- Trouble to fall sleep
- Low energy/fatigue
- Heaviness in the whole body
- Others: \_\_\_\_\_
- Sweating easily
- Angry easily
- Shortness of breath
- Thirst, prefer cold or warm
- Thirst, no desire to drink
- Depression/stressful anxiety
- Night sweating
- Frequent dreams
- Sleeping hours? \_\_\_\_\_
- Cold hands/feet
- Wake up easily

**Head/Ears/Eyes/Nose/Throat:**

- Headache
- Migraines
- Dizziness/vertigo
- Ringing in ears
- Others: \_\_\_\_\_
- Blurred vision
- Floaters
- Dry eyes/pain
- Hearing loss
- Nose bleeding
- Nasal discharge
- Sinus problem
- Earache
- Grinding teeth
- Sore throat
- Sore on lips/mouth
- Ear discharge

**Cardiovascular/Respiration:**

- Chest pain
- Palpitation
- Angina
- Poor memory
- Swollen ankles
- Others: \_\_\_\_\_
- Asthma
- Wheezing
- Bronchitis
- Shortness of breath
- Rapid heart beats (>90)
- Chronic cough
- Spit up blood
- Tightness in chest
- Shortness of breath on exertion
- Slow heart beats (<60)
- Difficulty breathing
- Spit up phlegm
- Arteriosclerosis

**Gastrointestinal:**

- Heartburn
- Gas
- Bloating
- Bad breath
- Gallbladder problem
- Others: \_\_\_\_\_
- Bulimia
- Mucus in stools
- Blood in stools
- Constipation
- Undigested food in stools
- Liver problem
- Hemorrhoids
- Anorexia
- Loose stool
- Abdominal pain/cramps
- Nausea
- Vomiting
- Belching

**Genitourinary:**

- History of bladder/kidney infection: \_\_\_\_\_ Yes / No
- Do you wake up to urinate? \_\_\_\_\_ Yes / No, how many times? \_\_\_\_\_
- Pain on urination
  - Blood in urination
  - Prostate problem
  - Urgent with urination
  - Unable to hold urination
  - Impotency
  - Frequent urination
  - Kidney stones
- Others: \_\_\_\_\_

**Gynecological:**

- Painful menstruation
- Heavy/light periods
- Endometriosis
- Unusual vaginal discharge
- Irregular periods
- Vaginal pain/itchiness
- Fibroids
- Clots
- PMS
- Menopausal symptoms
- Hysterectomy: \_\_\_\_\_ Yes / No
- Breast lumps
- Infertility

# of pregnancies: \_\_\_\_\_ # of births: \_\_\_\_\_ # of premature births: \_\_\_\_\_



# of miscarriages: \_\_\_\_\_ # of abortions: \_\_\_\_\_ # of days between menses: \_\_\_\_\_

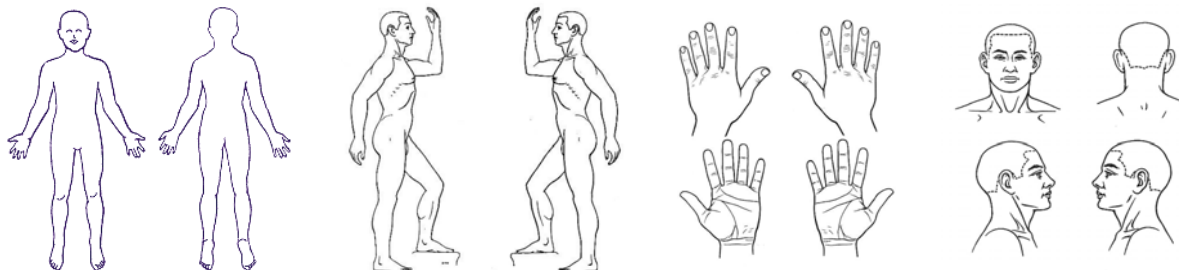
Are you pregnant? Yes / No On lactation: Yes / No Trying to be pregnant: Yes / No

Use birth control pills: \_\_\_\_\_

Others: \_\_\_\_\_

Other complaints: \_\_\_\_\_

**Please outline on the diagram the area of your discomfort:**



**Consent to Treatment:**

By signing below, I do voluntarily consent to be treated with acupuncture and/or other Chinese Medical modalities by a licensed acupuncturist.

I also acknowledge that, although rare, certain side effects may happen, like minor bleeding or bruises, post-acupuncture sensation (numbness, tingling, heaviness and tiredness), allergic reaction to the herbs, etc. I give my consent to have acupuncture and TCM treatment at South Calgary Acupuncture Centre.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR ACUPUNCTURIST USE ONLY**

Tongue: \_\_\_\_\_

Pulse: Right \_\_\_\_\_ Left \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TEL: (403) - 451 0096  
(403) - 650 3009

**SOUTH CALGARY ACUPUNCTURE CENTRE**

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