Calgary Acupuncture

General Information   Case#:______________ Date: D___M___Y____

Name:_First______________Last______________M__________Gender:______F___/___M_______
Date of Birth:__________________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 □HIV/AIDS □Arthritis □HT disease
□Cancer/Tumors □Venereal Disease □Thyroid Disease
□High/low blood pressure □Allergies (drugs, food, etc)
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 □Sweating easily □Night sweating □Cold hands/feet
□Nervousness □Angry easily □Frequent dreams □Wake up easily
□Trouble to fall sleep □Shortness of breath □Sleeping hours?____________________
□Low energy/fatigue □Thirst, prefer cold or warm □Thirst, no desire to drink
□Heaviness in the whole body □Depression/stressful anxiety
□Others:____

Head/Ears/Eyes/Nose/Throat:
□Headache □Blurred vision □Nose bleeding □Grinding teeth
□Migraines □Floaters □Nasal discharge □Sore throat
□Dizziness/vertigo □Dry eyes/pain □Sinus problem □Sore on lips/mouth
□Ringing in ears □Hearing loss □Earache □Ear discharge
□Others:____

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

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

Genitourinary:
History of bladder/kidney infection:________Yes / No________________________________
Do you wake up to urinate?____Yes / No____, how many times?________________________
□Pain on urination □Urgent with urination □Frequent urination
□Blood in urination □Unable to hold urination □Kidney stones
□Prostate problem □Impotency
Others:____

Gynecological:
□Painful menstruation □Irregular periods □Clots □Breast lumps
□Heavy/light periods □Vaginal pain/itchiness □PMS □Infertility
□Endometriosis □Fibroids □Menopausal symptoms
□Unusual vaginal discharge □Hysterectomy: ________Yes / No________

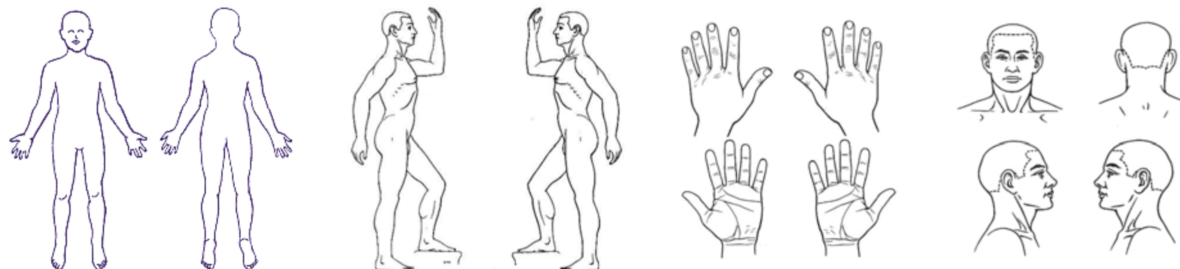
# of pregnancies:________ # of births: __________ # of premature births:_______________

# 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: __________________

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CALGARY ACUPUNCTURE

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