



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: _____
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:

- | | | | |
|------------------------------------|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypotension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> HT disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Alcoholics | <input type="checkbox"/> Others: _____ | |

Personal Health History:

- | | | | |
|------------------------------------|---------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Birth trauma | <input type="checkbox"/> Accident/Trauma |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> 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 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? _____

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: _____

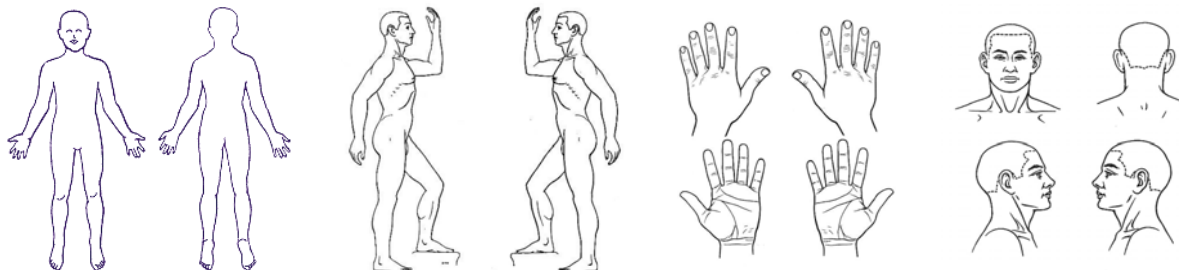
Are you pregnant? Yes / No On lactation: Yes / No Trying to be pregnant: Yes / No

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

Suite 130, 290 Midpark Way SE
Calgary AB T2X 1P1