Coastal Roots Health

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Acupuncture Patient History Form

To assist you with the best possible care, please fill out this form as accurately as you can. All information provided will be kept confidential.

Personal Information

Full Name: ____

Preferred pronoun:__________________________________

Today's Date: ______________________________________

Address:____

Phone (home): _____________________________________

City: ____________________________ Province: _______

Postal Code: ______________________

Phone (work):__________________________________

Phone (cell): ______________________________________

Email Address: _____________________________________

Care Card Number (if claiming treatment under MSP):

____

Occupation:____

Date of Birth: _______________Age:_____________

Height____________Weight:_________

Occupation:____

Emergency contact:_________________________________

Relationship: ______________________________________

What forms of treatment/therapy do you currently or have you used?

____

____

Physician (name and phone number):

____

Other healthcare team (physiotherapist/massage therapist/ naturopath/chiropractor etc.):

____

Have you received acupuncture before? Y / N

Have you taken Chinese herbs before? Y / N

Health History

Primary reason(s) for today's visit, in order of importance. Please include how long you've had it, how bad it is (1-10) what makes it better/worse, how it affects your sleep/work/relationships etc.:

____

____

____

____

____

Prescription drugs, over-the-counter drugs, supplements or herbs you are taking, and the condition you are taking them for:

____

____

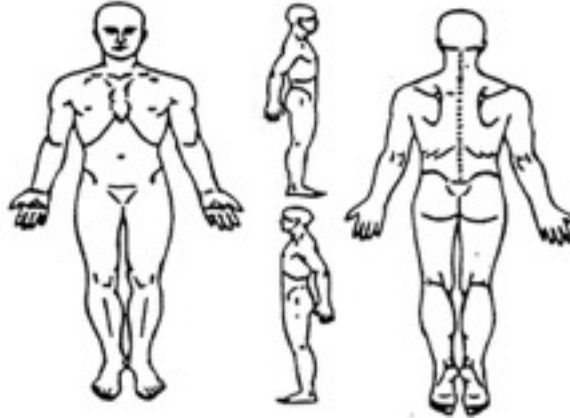
Major accidents, illnesses, infections, surgeries, etc.:

____

____

On the figures below, please circle any area(s) of pain or concern and indicate any factors that make it better or worse:

X X X = sharp/stabbing pain
OOO = dull/achey pain
//// = numbness/tingling
:::: = weakness



Lifestyle/Social History:

Stress level (0-10):_________ Energy (0-10):____________

Multiple sex partners? _________

Alcohol (drinks/week):________Coffee (cups/day):________

Smoker (or have ever been)? Y / N

Past/present recreational drug user? (amounts and types):

____

How is the health of your mother, father, siblings and grandparents?

____

Type and frequency of physical exercise:

____

Typical daily diet and any food intolerances/sensitivities:

____

____

Please check any that apply:

☐ Blood Thinners
☐ Pacemaker
☐ Seizure Disorder

☐ Scheduled Surgeries
☐ Possibility of Pregnancy
☐ Hemophiliac/bleeding disorders

☐ Asthma
☐ Needle Sensitivity
☐ Stroke

Traditional Chinese Medicine (TCM) Indicators

Check (C) if Current Symptom, and put (P) for Past symptom:

General
__Weight Loss
__ Weight Gain
__ Sweats/Night Sweats
__ Hot Flashes
__ Cold Hands and Feet
__ Hot Hands and Feet
__ Easily Heated/Chilled
__ Fever and/or Chills
__ Fatigue/Low Energy
__ Anemia

Head and Neck
__ Dizziness/Light-headedness
__ Fainting
__ Neck Stiffness
__ Headaches/Migraines

Skin & Hair
__ Hives/Rashes
__Easy/Spontaneous Sweating
__Dryness
__ Fungal Infections/Dandruff
__ Bruise Easily
__ Fine Hair/Falling Out
__ Nails Break Easily
__ Ridged Nails

Musculoskeletal
__Joint Pain
__Joint Swelling
__Body Aches
__ Muscles Cramps
__Paralysis
__Difficulty Walking
__Spinal Curvature
__Numbness/Tingling
__Body Heaviness
__Backache or Knee Pain

Nervous System
__Tremors

__Poor balance
__ Seizures
__ Numbness/tingling

Eyes & Ears
__Blurred Vision/Visual Changes
__Spots/Floaters
__Eye Pain
__Dry Eyes
__ Red/Burning Itchy Eyes
__ Ringing Ears
__ Poor hearing
__ Earaches/Infections

Nose Throat & Mouth
__Bleeding Gums
__ Sinus Infection
__ Hay Fever or Allergies
__ Recurring Sore Throat
__ Bitter Taste in Mouth
__Tongue Ulcers/Cankers
__ Nose Bleeds
__ Dry Mouth/Nose/Throat
__ Tooth/Gum Pain

Respiratory
__ Chronic Cough
__ Coughing up Blood
__ Coughing up Phlegm
__ Shortness of Breath
__ Shortness of Breath on Exertion
__ Wheezing/Asthma
__ Frequent Colds

Cardio Vascular
__Palpitations
__Rapid Heartbeat
__Irregular Heart Beat
__Chest Pains or Tightness
__Poor Circulation
__Swelling of Ankles
__High Blood Pressure
__High Cholesterol

Digestion
__Normal/Healthy Appetite
__Excessively Hungry
__Poor Appetite
__Need to Eat Frequently
__Hungry, But No Desire to Eat
__Prefer Warm Drinks
__Prefer Cold Drinks
__Excessively Thirsty
__ Not Thirsty
__Nausea
__Vomiting
__Acid Reflux/Heartburn
__Gas
__Hiccups
__Bloating
__ Abdominal/Intestinal Pain
__Bad Breath
__Loose/Soft Stools
__Constipation/Difficult Bowel Movement
__Black Stools
__Blood in Stool
__Mucous in Stool
__Itchy or Burning Anus
__Rectal Pain
__Hemorrhoids

Genito-Urinary
__Pain or itching of genitalia
__ UTI’s
__Painful Urination
__Frequent/Urgent Urination
__Excessive or Scanty Urine
__Blood in Urine
__Foamy Urine
__Dribbling Urination
__Incontinence
__Wake up to Urinate
__Bedwetting
__Kidney Stones

Sleep
__Sound/Restful
__Excessive Sleep
__Wake Up Easily/Early
__Difficulty Falling Asleep
__ Difficulty Staying Asleep
__Vivid Dreams/Nightmares
Hours of Sleep per Night____________

Mental/Emotional
__Anger
__Irritability
__ Frequent sighing
__Fear
__ Grief
__ Worrying
__ Anxiety
__ Forgetfulness
__ Cloudy thinking
__ Obsessive Behaviour
__ Lack of motivation
__ Nervous tics
__ Easily Stressed
__ Depression
__ Sadness
__ Abuse survivor

Sexual/Reproductive Health
__ Painful intercourse
__ Endometriosis
__ Vaginal Dryness
__ PCOS
__ Hysterectomy
__ High or Low Libido
__ Impotence
__ Infertility
__ Seminal Emissions
__ Premature Ejaculation
__ STD/STI’s

Menstruation & Fertility, if applicable:

Age of first period: _____ Length of cycle:________
Length of bleeding: __________
Please indicate if you experience any of the following between periods:
☐ Vaginal discharge
☐ Bleeding
☐ Cramps/Pain

Please indicate the quality of blood:
☐ Light red
☐ Dark red
☐ Bright red
☐ Clotted
☐ Light Flow
☐ Heavy Flow
Are you currently pregnant? Y / N
Are you trying to become pregnant? Y / N

If applicable, at what age did menopause begin?_____

If you experience any cramping, please indicate when?
☐ Before menstruation
☐ During menstruation
☐ After menstruation
Do you experience breast tenderness? Y / N
Yeast infections: Y / N
PMS: Y / N   Digestive changes: Y / N
How many pregnancies have you had?_________
Have you had any miscarriages? Y / N
Abortions? Y / N

Indicate any pregnancy-related difficulties:
____
____

Gender transitioning, hormonal therapies, surgeries (please list any additional info):

____

Please indicate any menopause-related symptoms:

☐ Hot flashes
☐ Insomnia
☐ Night sweats
☐ Mood swings
☐ Vaginal dryness
☐ Depression

Other:________________________

Welcome to Coastal Roots Health Centre! To your health and wellness.

The information on this form is complete and true to the best of my knowledge.

Patient Signature: ___________________________

Guardian Signature:________________________________
(if patient is under 16 years old)

Witness:_____________________________________

Date: __________________________