Glow Acupuncture and Wellness Centre

Please note that all information is strictly confidential

First name: _____ Last name: _____

Address: _____ City/Postal Code: _____

Email Address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____

Marital Status: _____ No. of Children: _____

Occupation: _____ Primary Physician: _____

Emergency Contact: _____ Phone #: _____

Who should we thank for referring you to this office: _____

Have you received acupuncture before, and if so, when? _____

Reason for Today's Visit: _____

_____

_____

How, when and where did this condition begin? _____

_____

_____

What types of treatments have you tried, if any? _____

_____

What makes it better? _____

What makes it worse? _____

Please list any other health problems you would like to address in order of importance: _____

_____

_____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, Major Accidents (include dates): _____

_____

_____

Immediate Family Medical History (Mother, Father, Siblings):

_____

_____

Current medications, supplements and vitamins (and what they are for):

_____

_____

_____

_____

_____

Do you currently have or have you ever had any of the following?

Anemia	Epilepsy	Fibromyalgia	Arthritis	Diabetes	Multiple Sclerosis
Emotional Disorder		Drug Problem	Digestive Disorders		Heart Problem
Pacemaker	Tuberculosis	Cancer	Hepatitis	HIV	Allergies
High Blood Pressure		Kidney Disease	Osteoporosis	Asthma	Stroke
Ulcers	Thyroid Problem	Kidney Stones	Gall Stones	Alcoholism	AIDS

Do you have any drug allergies? _____

Lifestyle:

How do you feel about your diet? _____

Do you crave any particular foods? _____

Exercise? Yes No How often? _____ Type? _____

Sleep: Hours per night _____ Rested in AM? _____

Trouble falling asleep? _____ Trouble staying asleep? _____

Do you get up to urinate more than once? _____

Work: Enjoy work? Yes No Hours per week working _____

Hobbies: _____

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee -				Water -			
Tobacco -				Recreational Drugs -			
Alcohol -				Soda pop -			

Have you ever been a smoker?

Symptom Survey (please check all that apply)

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0	1	2	3	4	low appetite	0	1	2	3	4	ravenous appetite
0	1	2	3	4	loose stools	0	1	2	3	4	heartburn/acid reflux
0	1	2	3	4	gas/abdominal bloating	0	1	2	3	4	mouth sores
0	1	2	3	4	fatigue after eating	0	1	2	3	4	belching or vomiting
0	1	2	3	4	hemorrhoids	0	1	2	3	4	gums bleeding/swollen
0	1	2	3	4	bruise easily	0	1	2	3	4	thirst
0	1	2	3	4	anemia	0	1	2	3	4	bad breath

0	1	2	3	4	abnormal sweating	0	1	2	3	4	fatigue
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	tired after little exertion
0	1	2	3	4	shortness of breath	0	1	2	3	4	general weakness
0	1	2	3	4	cough	0	1	2	3	4	nasal discharge
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	sinus congestion

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0	1	2	3	4	sore, cold or weak knees	0	1	2	3	4	feel cold often
0	1	2	3	4	low back pain	0	1	2	3	4	swollen ankles
0	1	2	3	4	frequent urination	0	1	2	3	4	poor memory

0	1	2	3	4	urinary incontinence	0	1	2	3	4	hair loss
0	1	2	3	4	ear/hearing problems	0	1	2	3	4	infertility
0	1	2	3	4	early morning diarrhea	low		normal		high	libido

0	1	2	3	4	irritable	0	1	2	3	4	muscle spasms/twitches
0	1	2	3	4	ligament/tendon issues	0	1	2	3	4	numb extremities
0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry, irritated eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing
0	1	2	3	4	sigh frequently	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	red eyes

0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	disturbing dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	restlessness
0	1	2	3	4	anxiety	0	1	2	3	4	palpitations

0	1	2	3	4	dizzy upon standing	0	1	2	3	4	feeling of heaviness
0	1	2	3	4	see floaters in eyes	0	1	2	3	4	nausea
0	1	2	3	4	heat in palms or soles	0	1	2	3	4	foggy thinking
0	1	2	3	4	afternoon fever	0	1	2	3	4	enlarged lymph nodes
0	1	2	3	4	night sweats	0	1	2	3	4	cloudy urine
0	1	2	3	4	frequently flushed face						

<u>Urination</u>: (Circle all that apply) Burning Urgent Scanty
Difficult Profuse Dribbling More than 1x a night

<u>Bowel Movements:</u> Frequency _____

Consistency (circle): well-formed hard loose alternates between formed and loose

Do you ever notice any undigested food, blood or mucous? _____

Are you thirsty? Yes No If so, do you crave warm or cold drinks? _____

Upon waking, do you have a bitter taste in your mouth? _____

Do you find that you "run" particularly hot or cold? _____

How is your energy in general? _____

Do you often get headaches or migraines? Yes No

How do you feel emotionally right now? _____

_____

Women Only:

Are you currently pregnant? _____ Are you on the birth control pill? _____

# of pregnancies_____ # of live births_____ # of miscarriages_____ # of abortions_____

How old were you when you had your first period? _____

Have you experienced menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe: _____

_____

Vaginal Discharge? Yes No

Is your period regular?_____ When was the first day of your last period?_____

# of days from the start of one period to the start of the next _____

Average number of days of flow: _____ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown Purple

Blood clots? Yes No

Do you get pain or cramps? Yes No Severe? Yes No

Nature of pain (circle): Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your menstrual period?

Water retention Breast tenderness/swelling Depression Irritability Migraines

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

_____

Men Only:

Date of last prostate check up: _____ Results: _____

Circle all that apply: Groin pain Decreased libido Testicular pain Impotence

Painful urination Difficult urination Dribbling urination Incontinence

Premature ejaculation Nocturnal emissions Increased libido

Other: _____

_____

I am committed to your health and well-being. While Chinese Medicine is a very thorough health care system, it is not a replacement for western medical treatment, including regular check ups with your primary care physician. I recommend that you consult a physician regarding any condition for which you are seeking acupuncture treatment. We, the undersigned, do affirm that _____ (print patient name) has been advised by Sabeeha Kurji/Courtney Morris/Sally Horne to consult a physician regarding the conditions for which such patient seeks acupuncture treatment.

Patient Signature: _____ Date:_____

Practitioner Signature: _____ Date:_____

I consent to acupuncture treatment and other procedures associated with Traditional Oriental Medicine. I have discussed the nature of my treatment with my practitioner. I understand that methods of treatment may include but are not limited to: acupuncture, massage, moxibustion, gua sha, cupping, electric stimulation, and Chinese herbal medicine. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include pneumothorax and organ puncture. Slight superficial burns are a possible side effect of moxibustion.
I acknowledge that if I do not give 24 hours notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

Patient Signature: _____ Date: _____