Contemporary Acupuncture for Health Professionals

Patient Information Sheet

NAME: *Please Print* ____

Please answer the following questions about your family medical history:

Has anyone in your family had: Heart Disease? ☐; High Blood Pressure? ☐; Diabetes? ☐; Cancer? ☐; Other Diseases? ☐ Specify Whom: ____

Please check the appropriate symptom if you have ever experienced it:

HEAD AND NECK

Headaches ☐	Hearing Problems ☐	Ringing of the Ears ☐
Vertigo ☐	Dizziness ☐	Eye Problems ☐
Vision Problems ☐	Nose Problems ☐	Temporomandibular Problems ☐
Sinusitis ☐	Cavities ☐	Other Mouth Problems ☐
Sore Throat ☐	Neck Pain ☐	Voice Changes ☐

Other problems in these areas (specify): ____

CHEST, LUNG, HEART, AND SKIN

Chest Pain ☐	Palpitations ☐	Blood Pressure Problems ☐
Tachycardia ☐	Chest oppression ☐	Excessive Dreaming ☐
Insomnia ☐	Night Sweats ☐	Excessive or Little Sweating ☐
Lung Problems ☐	Asthma ☐	Shortness of Breath ☐
Allergies ☐	Skin Problems ☐	Restlessness, Irritability ☐

Other problems in these areas (specify): ____

DIGESTIVE SYSTEM AND MISCELLANEOUS

Bleeding Gums ☐	Belching ☐	Nausea, Vomiting ☐
Heart Burning ☐	Poor Appetite ☐	Loss of Taste ☐
Bloating ☐	Abdominal Pain ☐	Bowel Movements After Meals ☐
Sleepy After Meals ☐	Gas, Rumbling ☐	Diarrhea ☐
Constipation ☐	Haemorrhoids ☐	Gaining or Losing Weight Easily ☐
Bruising Easily ☐	Heavy Legs ☐	Varicosities ☐

Other digestive problems (specify): ____

GYNECOLOGICAL SYSTEM

Painful Periods ☐	Heavy Periods ☐	Irregular Periods ☐
Long Periods ☐	Absent Periods ☐	Pre-Menstrual Syndrome ☐
Hot Flashes ☐	Endometriosis ☐	Painful Intercourse ☐
Fertility Problems ☐	Breast Problems ☐	Miscarriages, Abortions ☐

Other gynecological problems (specify): ____

LIVER AND GALL BLADDER

Liver Problems ☐	Sweaty Palms ☐	Sweats Easily ☐
Irritated Easily ☐	Brittle Nails ☐	Bitter Taste in Mouth ☐
Muscle Cramps ☐	Anxiety ☐	Tension Headaches ☐
Slow Digestion ☐	Restlessness ☐	Stiff Joints and Muscles ☐

KIDNEY, URINARY TRACT, ENDOCRINE SYSTEM, AND VARIOUS

Kidney Stones ☐	Kidney Problems ☐	Urinary Bladder Problems ☐
Prostatitis ☐	Frequent Urination ☐	Urinary Tract Infections ☐
Incontinence ☐	Low Sexual Drive ☐	Erectile Dysfunction ☐
Feeling Cold ☐	Feeling Hot ☐	Feeling Low Energy ☐
Cold Hands ☐	Cold Feet ☐	Joint Pain ☐
Weak or Sore Knees ☐	Low Back Pain ☐	Bone Problems ☐

Please mention any muscle/joint problem of any other problem anywhere else: ____________________________

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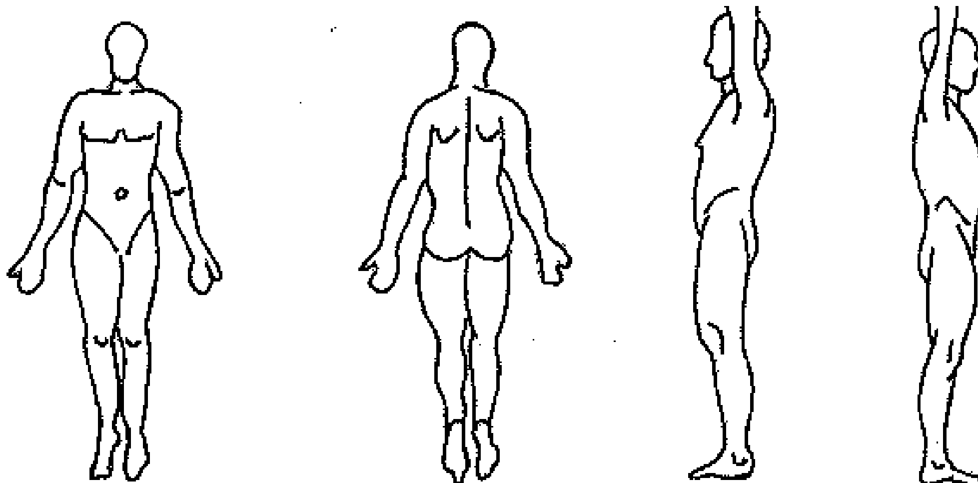
Contemporary Acupuncture for Health Professionals

Patient Information Sheet

Name: ______________________________________ Date of Birth (day/month/year) _____/_____/_____
Address: (home/business) ____
City:_____________ Province: _____________ Country: _____________ Postal Code: _____________
Telephone: Home (   ) ___-_____ Office: (   ) ___-_____ Fax: (   ) ___-_____ Cell: (   ) ___-______
Occupation: _______________________________ Smoking: Yes ☐ No ☐ # of cigarettes/day:___________
Marital Status and # of Children: ____
Family Doctor's Information: ____
Referring Doctor's Information: ____

Please answer the following questions:

1. What are the main reasons you wish to see the Doctor? Pain ☐; Fatigue ☐; Sleep Problems ☐; Menstrual Problems ☐; Other Problem ☐ (please specify): ___________________________________
2. Please use the following drawings to mark the areas where you have pain:



3. Mark in this scale what is your level of pain today (T), and in general (G)

   (0 = no pain) 0 ------1------2------3------4------5------6------7------8------9------10 (10 = worst pain)
4. Mark the treatments that you have received so far for your pain/fatigue or other problems?

   Medication ☐ Physical Therapy ☐ Chiropractic ☐
   Osteopathy ☐ Relaxation ☐
   Other Treatments (please specify): ____
5. So far, which treatments have benefited you the most? ____
6. List all the medications and supplements you are taking, or have taken recently: ________________
   ____
7. What do you expect from the Contemporary Acupuncture Treatments? ________________________
   ____
8. If you have several symptoms, what is your wish list? ____

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