TCM Acupuncture Health History Form

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| First Name | Middle name: |
| Last name: |  |
| Name prefer to be called: | Pronoun: |
| Sex: F M Other |  |
| Address: Number and Street: | Apt # |
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| City: Province: | Postal Code: |
| Home/ other tel no: | Cell no: |
| Referred by: | Occupation: |
| Marital status: |  |
| Name of family doctor: |  |
| Address: | Tel no: |
| Emergency Contact Information: |  |
| Name: | Tel no: |
| Relationship to Patient: |  |
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**Past Medical History**

Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.

Have you ever suffered/ or are you currently suffering from any of the following: If ‘Yes’ don’t please include it in your history.

Appendicitis, Diabetes, Epilepsy, Pneumonia, Mumps, Pneumatic fever, Malaria, Venereal disease, Multiple Sclerosis, Measles, Influenza, Arthritis, Chicken pox, Cold sores, Anemia, Goiter, Gout, Rubella, Alcoholism/Addiction, Whooping cough, Heart Disease, Eczema, Polio, Parkinsons, Osteoporosis, Cancer, Tuberculosis, Mental illness, Pleurisy, HIV/AIDS.

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| **Hospitalization/injuries/surgeries/past medical conditions:** | **Dates:** |
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| **Family medical conditions or diseases that may be relevant.** | **Relationship to patient:** |
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**Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment**

Please list any ongoing health conditions, allergies, drug reactions, and long-term treatments that may be relevant.

If you are currently taking any prescription medications, please include them.

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| **Ongoing health conditions, allergies, drug reactions, and long-term treatments that may be relevant.** | **Dates:** |
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| **Prescription Medication:** |  |
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**Please indicate any conditions you are experiencing (past or present).**

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| General Symptoms:  Headaches/Migraines  Fever  Chills  Sweat  Memory Loss  Dizzy/Light Headed  Fainting  Stress/Depression  Discoordination  Nervousness  Recent Weight change  Numbness or pain in arms, legs | Cardiovascular:  High/Low Blood Pressure  Strokes or TIA’s  High cholesterol  Ankle swelling  Poor circulation  Stroke/Heart attack  Irregular heart rate  Shortness of Breath  Pain over heart | Muscle and Joint:  Stiff neck  Backache  Joint Swelling  Painful tailbone  Shoulder pain  Hernia  Spinal curvature  Poor posture  Arthritis  Foot trouble |
| Respiratory:  Wheezing  Chronic Cough  Spitting phlegm  Chest pain  Difficult breathing | Skin:  Skin conditions/rashes  Itching  Bruise easily  Dryness  Boils  Varicose Veins  Sensitive Skin  Hives or allergies | Genitourinary:  Frequent urination  Painful urination  Blood in urine  Kidney stones  Kidney/Bladder/Urinary tract infection  Incontinence |
| Uterine and Breast Health:  Cramps/Backache  Previous Miscarriage  Irregular cycle  Vaginal Discharge  Breast Lumps  Menopausal Symptoms  Pregnant  Painful menses  Irregular blood-flow  Hysterectomy | Ears, Eyes, Nose, Throat:  Hearing Loss  Vision Problems  Glaucoma  Tinnitus  Eye pain  Deafness  Earache  Ear discharge  Nose Bleeds  Nasal Obstruction  Asthma  Sore throat  Hoarse voice  Tooth Decay  Gum problems  Frequent colds  Enlarged thyroid  Tonsilitis  Sinus infection  Nasal Drainage  Enlarged Glands | Gastrointestinal:  Poor appetite  Food sensitivities  Intestinal distress  Excessive hunger/thirst  Belching/gas  Nausea  Vomiting  Burning in stomach  Pain over stomach  Constipation  Diarrhea  Colon problems  Liver disease  Gallbladder disease  Ulcers  Colitis  Hemorrhoids  Hypoglycemia  Hiatal hernia  Metallic tase  Mucus in stool |

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substitute Decision-Maker:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last update to patient health summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate that you have read and understand our clinic policies: