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Patient History for TCM & Acupuncture

PATIENT INFORMATION

Full Name: _____ Date: _____
Day/Month/Year

Date of Birth: _____
Day/Month/Year

Gender: Male Female Transgendered

Ethnicity: _____

Full Address: _____

Telephone: (home) _____ (work) _____

(mobile) _____ Email: _____

Emergency Contact: _____ Relationship: _____

(_____) _____ (_____) _____ (_____) _____
Telephone (home) Work Mobile / Pager

Marital Status (circle): Single Married Divorced Separated Living with Partner Widowed

Do you have any children? Y N

If yes, list age and gender. _____

Name of Medical Doctor: _____ Tel: (_____) _____

Address: _____ Fax: (_____) _____

Are you under the care of any other health care providers?

(name) (specialty)

(contact)

(name) (specialty)

(contact)

How did you hear of this clinic/who were you referred by? _____

Occupation? _____

MEDICAL HISTORY

Please list your chief health concerns or any conditions that you currently suffer from:

Chief Concern	Since	Comments
1.		
2.		
3.		
4.		
5.		
6.		

Please describe your expectations and goals of treatment:

Please circle any significant illness you have sustained (Acupuncture may not be suitable for some people suffering from these conditions. Please speak to your practitioner for further advice.):

AIDS	Hemophilia or bleeding disorder or blood thinners	Heart / Coronary Disease
Alcoholism or drug use	Hepatitis A B or C	Mitral valve prolapse (MVP)
Cancer	HIV (+)	Pituitary disorder
Diabetes	Seizures	Pacemaker
Thyroid Disease	Significant trauma or injury (fall, car accident)	Migraine headaches
High Blood Pressure	Other (please specify):	

Please list any traumas (mental, emotional or physical), surgical procedures, or serious illnesses you have sustained.

Event	Date	Complications / Results

MEDICATIONS / SUPPLEMENTS / DRUGS

Please list all current medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Drug / Supplement (Brand & Product Name)	Used For	Date Started	Dosage / Frequency

ALLERGIES, SENSITIVITIES, EXPOSURES

Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

FAMILY HISTORY

Please indicate if any of your immediate family (M=mother, F=father, S=sister, B=brother, MGM=maternal grandmother, MGF=maternal grandfather, PGM=paternal grandmother, PGF=paternal grandfather) suffers from or has suffered from any of the following conditions.

Condition	Family Member(s)	Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism/ Drug use		IBD (Crohn's Disease, Ulcerative Colitis)		Kidney Disease	
Allergies / hay fever		Depression/ Anxiety		Liver Disease	
Asthma		Diabetes		Overweight / Obesity	
Arthritis		Heart Disease		Prostate Cancer	
Breast Cancer		High Blood Pressure		Other Cancer	
Colon Cancer		Hyperthyroidism / Hypothyroidism		Stroke	

Any other conditions?

REVIEW OF SYSTEMS Please check all that apply.

Lifestyle Habits (currently or history of)

- Alcohol (amount/frequency): _____ Marijuana (amount/frequency): _____
 Tobacco (amount/frequency): _____ Antacids (amount/frequency): _____
 Stress Level /10 (0=none, 10=highest) Sources of Stress: _____
 Regular Exercise
 Type, Frequency, Duration, Intensity: _____

General Symptoms

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Strong appetite | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Peculiar taste | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heavy sleeper |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Prefer cold drinks | <input type="checkbox"/> Dream disturbed sleep |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Prefer hot drinks | <input type="checkbox"/> Difficulty Falling Asleep |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Recent weight loss/gain _____ | |
| <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> Vertigo or dizziness _____ | |

Head, Eyes, Ears, Nose, Throat

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> other head/neck problems |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> TMJ | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Excessive phlegm (nose/sinus) | |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Colour /consistency of phlegm: _____ | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Wet Cough | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Dry Cough | <input type="checkbox"/> Asthma/Wheezing |
| | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Colour /consistency of phlegm _____ | |

Cardiovascular (currently or history of)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain/Angina | <input type="checkbox"/> Rapid pulse |
| <input type="checkbox"/> Arterial Disease | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> sensation of heaviness or pressure on chest | |

Gastrointestinal

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain/cramps | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Undigested Food in stool | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Mucus in stool | <input type="checkbox"/> Greasy stool |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Itchy anus | <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Burning anus | <input type="checkbox"/> Gas (flatus) | <input type="checkbox"/> Black stools | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Gas (belching) | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Anal fissures | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Bloody stool |

Musculoskeletal

- | | | | |
|---|--|-------------------------------------|---|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited movement |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use |

Other (describe) _____

Skin and Hair

- | | | | |
|--|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in hair/skin |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infections |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Other hair/skin problems: _____ | | | |

Neuropsychological (currently or history of)

- | | | | |
|-----------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered or |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> attempted suicide |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Seeing a therapist |

Genito-Urinary

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Kidney stone |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> PMS | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Clotted menstrual blood |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores |
| <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Age menses began: _____ | <input type="checkbox"/> Age at menopause _____ | |
| <input type="checkbox"/> Last Menstrual Period (Day 1): _____ | <input type="checkbox"/> Typical # days of blood flow: _____ | | |
| <input type="checkbox"/> Length of cycle (day 1 – day before next day 1): _____ | | | |
| <input type="checkbox"/> Colour / consistency of blood: _____ | <input type="checkbox"/> Date last PAP: _____ | | |
| <input type="checkbox"/> # Pregnancies _____ | <input type="checkbox"/> # live births _____ | <input type="checkbox"/> Premature births _____ | <input type="checkbox"/> # miscarriages _____ |

Is there any chance you are pregnant now? Y N

Are you currently lactating? Y N

Additional Questions:

1. Temperature:

- Do you tend to feel hot or cold more often (i.e. compared to others)?
Do you need to cover up/ wear extra layers?
Do you prefer to eat hot/neutral/cold temperature food?

2. Thirst:

- Do you have strong thirst?
Thirst with desire to gulp fluids or sip slowly?
Little or no thirst?

3. Perspiration:

- Heavy perspiration?
Little or difficult perspiration?
Spontaneous sweating (no cause)?
Location of perspiration?
Odour (describe)?
Discolouration?

4. Energy:

- Rate your average daily energy level: ____ /10 (10 highest)
Best time of day?
Worst time of day?

5. Respiration & Voice:

Do you tend to speak in a loud or soft voice?
Shortness of breath?
Ongoing cough?
If so, any sputum? Describe (bloody, colour, consistency):

6. Sleep:

How do you like to sleep (i.e. with socks on/off, heavy blankets, open window, etc)?

At what times do you typically go to sleep and awaken?

Do you wake during night? At what time? From what?

7. Vision & Hearing:

Changes to/problems with vision?

Blurriness? Floaters? Dry eyes?

Changes to / problems with hearing?

Any ringing in ears? Since when?
Is the noise constant or intermittent? High or low pitched?

8. Digestion:

Number of bowel movements per day?
Consistency/Form/Shape/Texture?
Colour?
Timing?

9. Urine:

Is your urine copious and pale?
Is your urine scanty and dark or cloudy?
Frequency (every ____ waking hours)?
Any blood in the urine?
Any change in urgency, frequency or volume?
Pain or difficulty starting?

10. Reproductive:

Is your menstrual flow heavy, moderate or light?
Colour of blood (orangey, bright red, dark red, purplish, brownish, etc...)?
Any Clots? Size?
PMS: pain? Bloating/water retention?
Breast tenderness? Mood change?

Rate/describe your libido?

Any vaginal or penile discharge? Colour/consistency/odour?
Erectile dysfunction?
Infertility?