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Traditional Chinese Medicine & Acupuncture
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Twelfth Avenue Acupuncture and Herb Clinic

Personal and Confidential

Please read the following carefully.
Thank you for your interest in Traditional Chinese Medicine, TCM & TCM Acupuncture. TCM & TCM Acupuncture can be used for treatment and prevention.

All patients are urged to consult their own family physician, or specialists regarding current or future conditions. TCM & TCM Acupuncture is meant to be used as a complementary treatment.

Your treatment may be covered under your health insurance plan or with SGI.

Please ask if you have any questions.

I have read and understand the above information.

Signature: _____ Date: _____

Personal Data
Name:_____ Sex:_____ Age:_____ Birth Date:_____

Address:_____ City:_____ Prov:_____

Postal Code:_____ Email:_____Telephone: (H)_____
Work: (W)_____ Cell: (C) _____ Fax: _____
How did you hear about my office: □friend □phone book □sign other_____ Occupation: (your)_____
Emergency Contact Name: _____ Daytime # _____ Other # _____
Reason for todays visit _____

_____

_____

_____

How long have you experienced the Chief Complaints_____

_____

_____

How have they progressed_____

Physician's Diagnosis_____

_____

_____

Other recent or current treatment □MD_____ □Chiropractor _____ □Massage Therapist _____
□Physiotherapist_____ □Naturopath _____ □Specialist _____ □Fertility Clinic _____
□Other _____

What were the results of the treatments _____

_____

Have you had **Traditional Chinese Medicine** acupuncture before? □yes □no
Have you had other forms of acupuncture before? □yes □no
Have you taken **Traditional Chinese Medicine** herbals before? □yes □no

Are you taking any prescription or over-the-counter medications? □yes □no If yes, please list below.

Name	Dosage	How Often	Why?

Are you taking any vitamins/supplements/herbs? □yes □no If yes, please list below.

Name	Dosage	How Often	Why?

Please indicate a "P", "C" or "F" if any of the health conditions below apply to you.

P= Past C= Current F= immediate Family history

____Heart Condition ____Respiratory Disorder ____Headaches ____Stroke ____Kidney Disorder
____Jaw Pain ____High/Low Blood Pressure ____Cancer ____Arthritis ____Diabetes
____Hepatitis ____Dizziness/Fainting ____Deep Vein Thrombosis ____AIDS ____Contagious Infectious Illness
____Neurological Condition ____Sprain/Strain/fracture ____Skin Condition ____Spinal or Head Injury
____Osteoporosis ____Digestive Problems

Please inform your TCM practitioner if any of the following apply to you:

Are you pregnant □yes □no □unsure □trying
Problems with needles □yes □no

Wear a pacemaker □yes □no
Any surgeries scheduled □yes □no

Have other electrical implants □yes □no
Seizures □yes □no

Have/have had Herpes Simplex (Cold Sore) □yes □no
Have a common cold □yes □no

Have bleeding/bruising problems □yes □no specify_____ (Hemophiliac/anticoagulant medications)
What allergies do you have? _____
Are you at any particular risk of infection? _____(low white blood cell count)

Bowel Movements
How many bowel movements do you have per day _____ Are they well formed/dry/loose/many small ones/other _____
Do you have a tendency to constipation or diarrhea _____

Urination
How many times is water passed per day _____ Most of the time is the color clear/light yellow/dark yellow/other _____
Do you have to wake up in the middle of the night to pass water always/often/sometimes/very rarely/never

Digestion, Appetite, Diet
How do you feel your digestion is excellent/good /poor/other _____
Why _____

_____

Describe what your diet is like _____

_____

How is your appetite _____

Do you have any cravings (sweet, salty, etc)_____

Do you have heartburn/cramping/bloating

Thirst
What beverage temperature you prefer to drink cold/room temperature/hot

Body Temp
Are you one to turn up the heat in a room or turn it down? _____

Sweating
Do you sweat □on exertion □spontaneously □at night □other _____

Pain
1 Area _____ □Pain □Numbness □Burning □Tingling/Pins and Needles □Other _____
2 Area _____ □Pain □Numbness □Burning □Tingling/Pins and Needles □Other _____
3 Area _____ □Pain □Numbness □Burning □Tingling/Pins and Needles □Other _____
4 Area _____ □Pain □Numbness □Burning □Tingling/Pins and Needles □Other _____
Please Fill in the following chart

Area	Pain Level 0 (Pain Free) –10 (unbearable)	How often is the pain (Example 1/day, constant, 1/week)	When did the pain start	Why do you think it started	What makes it feel worse	What makes it feel better	Is the pain dull or sharp	Is it worse at different times of the day	Do you take any painkillers of anti-inflammatories for the pain If so, what and how many	Has it been getting worse or better since it started
1										
2										
3										
4										

Is the pain relieved by □heat □cold □neither □unsure □other_____
Is the pain worse with different kinds of weather □hot □cold □damp □unsure □other_____

Emotions

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning • **Moderate** = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe
Sad				
Irritability				
Over thinking				
Fear				
Nervous				

Sleep and Energy Level

On Average, how many hours do you sleep per night? _____

Do you wake up in the middle of the night? If so how often_____

Do you have □a lot of vivid dreams □a few dreams □not many at all

How is your energy level_____

Lifestyle

Do you □smoke how much _____ □drink alcohol how much _____

□caffeine how much _____ □exercise how much _____

Work _____hrs/week

Surgeries/Procedures

List surgeries

YEAR _____	YEAR _____
YEAR _____	YEAR _____

Illnesses

List physician diagnosised illnesses

YEAR _____	YEAR _____
YEAR _____	YEAR _____

Family Health History Mother _____

Father _____

Other _____

Women

How many days do you bleed for _____ How heavy is your flow _____

What color is the blood _____ How long is your cycle _____

Any pain with your period _____

Is it □before □during □after your period Is the pain alleviated □hot □cold

Does pressing the area make the pain feel □better □worse □no effect

Do you get PMS? _____

What is it like? _____

Have you ever had a miscarriage or D&C _____ How many children do you have _____

How old were you when you had your first period _____

How old were you at menopause _____

What is it like? _____