ACUPUNCTURE FOR HEALTH

WENDY STALKER R.Ac. Dip.Ac. B.Sc.

Name:		Date of Birth:	Date:
Address: Postal Code:			☐ Male ☐ Female
Occupation:			
Telephone: Day: Cell Phone:	Evening:		
E-mail address:			
Emergency Contact:	Telephone:		

Where did you hear about Acupuncture for Health? ____________________

____

Is there someone we can thank for the referral? ____________________

____

Have you ever received acupuncture treatments: Yes ☐ No ☐

If yes, for what were you treated? ____________________

____

Please check if any of the following apply to you:
Hemophiliac; Wear a pacemaker; Have a serious heart or lung condition;
Taking anticoagulant medications; Epilepsy; Pregnant; Contagious condition

Current Medications: (prescription medications, other medications, herbs, vitamins etc.)____________________

____

Side Effects (if any) of current medications: ____________________

____

Initial and successive treatments: Regular - $75.00; Facial - $90.00
Prepayment Plan – Ten Treatments - $700.00; Facial - $850.00

Payment Options: Debit ☐ VISA ☐ MasterCard ☐ Cash
Give yourself the gift of vital health.

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Health History

Please indicate your top 3 health concerns and how long you have experienced them:

1. ______________________________
   ____
2. ______________________________
   ____
3. ______________________________
   ____

What other forms of treatment have you sought?

____

____

What helps your condition?

____

____

What makes it worse?

____

____

What are you hoping to gain from acupuncture sessions?

____

____

Please list any surgeries or major health incidents (accidents, etc.) When did they first occur?

____

____

____

Are you currently experiencing pain? Yes / No

If yes, where: ___________________________

Sensations / pain:

Sharp Stabbing Scurrying Throbbing Cold Burning; Dull Shooting; Tingling

Numbness Fullness Aching Heavy Sore Dragging Empty Fixed Twisting Other

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General History:

Mouth: Taste in mouth: Tasteless Bitter Sweet Sour Salty
Dry Damp Numb Other ____________

Thirst: NOT feeling thirsty after water intake Feeling thirsty with desire to drink plenty of water
Feeling thirsty with no or little desire to drink water
Feeling dry in mouth with desire to moisten with water Other ________________

Teeth & Gums: Swollen gums Bleeding gums Toothache Mouth sores / canker
Other ____________

Nose and Throat: Sinus infections Nose bleeds Hay Fever / Allergies Recurring sore throat
Swollen glands Hard to swallow Other ________________

Eyes: Eye pain Spots/floaters Blurred vision Poor night vision Double vision (diplopia)
Dry eyes Red/burning or itchy Other ___________

Ears: Ringing in ears (tinnitus) Reduced hearing Earaches Recurring infections
Other ____________

Head, Neck, Chest, Abdomen and Extremities: Dizziness (vertigo) Nausea Neck stiffness
Chest pain / tightness Heart palpitations Irregular heartbeat Flank fullness
Stomach fullness/bloating Abdominal fullness/bloating Numbness, where_____________
Itchy, where ______________ Heavy body Lack of strength Lack of energy, sluggish
Swollen ankles Edema Other _________

Urinary: Painful urination Frequent urination Urgent urination Urinary incontinence
Excessive urination Scanty urination Blood in the urine Wake up to urinate Bedwetting
Kidney stones Other _____________

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Bowel movements: Loose or soft stools Constipation Alternate loose / constipation Laxative use Black stools Blood in stools Mucous in stools Undigested food in stools Itchiness or pain in anus Burning anus Rectal pain Anal fissures Hemorrhoids
Other ________________

Chills: Aversion to wind Aversion to cold Shivers Other ____________

Fever: Fever, body temperature Hot flashes Alternate attacks of chills and fever
Other ______________

Sweating: Spontaneous sweat Night sweat Excessive sweat on head or neck
Sweat on left/right/upper/lower side of the body Excessive sweat on hands and/or feet
Excessive sweat on chest Excessive sweat on genital area Other: _____________

Sleep: Restful Light Hard to fall asleep Wake up easily/early Dream Disturbed
Nightmares Heavy sleep Hours of sleep / night ______ Other _____________

Appetite: Poor appetite Loss in appetite Ravenous appetite Hunger with no desire to eat
Food flavoured with sweet/salty/spicy/sour/bitter spices or herbs Other ______________

Skin: Itchiness Dryness Mole or lump changes Bruise easily Fine hair / Falling out
Nails break easily Rashes Eczema Psoriasis Acne Hives Other _______________

Emotions: Relaxed and calm Sad Fearful Depressed Angry / Frustrated Irritated easily
Anxious Stressed Over thinking / worry Forgetful Manic Impatient
Other _________________

Is there anything we have missed?

____

____

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For Women:

Vaginal Discharge:

Colour: White Yellow Green Pink Red Other ________

Consistency: Watery Thick Sticky Other________

Odour: None Unpleasant Other_________

Menstruation History: (Fill this section if pre-menopausal)

How old were you when your period first started? ________

Is your cycle regular / irregular (early / late)?

Usual number of bleeding days: _______

Is your flow: Light / Moderate / Heavy

Blood colour: Fresh red / Scarlet red / Dark red / Pink / Purple / Brown / Black

Blood consistency: Watery-thin / Thick / Average

Does your flow have clots? Yes / No

Size of clots: Small / Moderate / Large

Do you experience any menstrual pain? Yes / No

If yes, at what point during the cycle: Before / During / After flow

If yes, what type of pain: Cramping / Stabbing / Heavy / Dull / On and off

What relieves the pain? Pressure / Heat / Cold / Other ____________________

Do you have nipple sensitivity or discharge? Yes / No

Is there any spotting/bleeding between cycles? Yes / No

Menopausal History: (Fill this section if menopausal)

How old were you when your period last started? ________

Are there any menopausal symptoms?

No Yes ____

Is there any vaginal bleeding since menopause? Yes / No