

Confidential Acupuncture Health History

Patient Information

Name: _____ D.O.B(D/M/Y) _____

Address: _____ Postal Code: _____

City: _____ Home Phone #: _____

Cell Phone #: _____ Occupation: _____

Family Doctor: _____

Emergency Contact: _____ Phone #: _____

Acupuncture History/Treatment Information:

Have you had Acupuncture before? YES/NO

If yes, when? _____ What for? _____

Please list your major health concerns in order of importance:

Complaint:	Since:	Possible Cause:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have these conditions/complaints been diagnosed by a physician, or other provider? YES/NO

Are you currently seeing a Medical Practitioner, Chiropractor or Physiotherapist etc? YES/NO

If yes please explain: _____

Are you currently taking any medication? (Prescription/Herbal/Over the Counter/Supplements)
YES/NO

If yes, what and how often? _____

Do you have allergies? YES/NO If yes, please list all: _____

Lifestyle: Smoking Alcohol Coffee/Caffeine Other Drugs

What do you do for exercise and frequency? _____

Have you ever had a problem with alcohol or alcoholism? **YES/NO**

Have you ever had a problem with dependency on drugs? **YES/NO**

Do you have any known history of exposure to any toxic substances? **YES/NO**

Have you ever been treated for emotional issues? **YES/NO**

Have you ever considered or attempted suicide? **YES/NO**

Do you have any other neurological or psychological concerns? **YES/NO**

Previous History: *Include Year and Treatment received*

Surgeries: _____

Accidents: _____

Please check all symptoms which are current in the last three months:

- | | |
|--|--|
| <input type="checkbox"/> Diarrhea/Loose Stool/IBS | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Constipation/Bloating/Gas | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Epigastric (Stomach) Pain | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Tiredness/Fatigue |
| <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Blurred/Double Vision |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Hot/Cold Intolerances |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Frequent Colds/Flus |
| <input type="checkbox"/> Dribbling Urine | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Low Back/Knee Pain | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Persistent Thirst/Hunger | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Tinnitus |

Please check/circle any other conditions or symptom(s) presently or recently experienced:

Musculo-Skeletal

- | | |
|--|--|
| <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> Spasms/Cramps |
| <input type="checkbox"/> Tendonitis/Bursitis | <input type="checkbox"/> TMJ/Jaw Pain |
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Lupus/Fibromyalgia |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tension Headaches/Migraines |
| <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Low Back/Hip/Leg Pain | <input type="checkbox"/> Mid back/Shoulder Pain |
| <input type="checkbox"/> Neck Pain/Arm Pain | <input type="checkbox"/> Sciatica |

Circulatory/Nervous System

- Heart Disease
- Varicose Veins
- Blood Clots
- Shingles/Herpes
- Heart Attack
- Swelling/Lymphedema
- Bruises Easy
- Phlebitis
- Paralysis
- Stroke
- Neurological Disorder
- Other _____

Digestive System

- Diverticulitis
- Acute Stomach Pain
- Hernia
- Liver/Gallbladder Issues _____

Skin

- Psoriasis
- Hives/Rash
- Athletes Foot
- Warts
- Eczema
- Open Sores/Cuts

Infectious Disease(s) _____

Other

- HIV/AIDS
- Cancer/Tumors
- Hepatitis
- Tuberculosis
- Concussion
- Anaphylaxis
- Altered Taste/Smell
- Glaucoma
- Hyper/Hypothyroid
- Epilepsy
- Diabetes
- Hemophilia
- Pacemaker
- Asthma
- Hearing Loss
- Drug/Alcohol Abuse
- Mental Illness
- Paralysis

Female Only:

Are you Pregnant? YES, How many months? _____ NO Trying Maybe

Method of Birth Control? _____

Age of First Menses? _____ Date of Last Menses? _____

Typical Length of Menses? _____ Typical Length of Cycle? _____

Number of: Pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Menopause? **YES/NO** If yes, Age of Menopause _____ Hysterectomy? **YES/NO**

Please Check all that Apply to you:

- Scanty Flow
- Clotting
- Painful Periods
- Breast Lumps
- PMS
- Endometriosis
- Painful Intercourse
- Menopausal Symptoms
- Excessive Libido
- Heavy Flow
- Vaginal Discharge
- Breast Tenderness
- Infertility
- Bleeding Between Cycles
- Ovarian Cysts
- Fibroids/ Fibrocystic Breasts
- Low Libido
- Nipple Discharge

- UTI
- Irregular/Early/Late Cycles

- Morning Sickness
- Other: _____

Men Only:

Please Check all that Apply to you:

- | | |
|--|--|
| <input type="checkbox"/> Low Libido | <input type="checkbox"/> Excessive Libido |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Seminal Emissions |
| <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Testicular Pain |
| <input type="checkbox"/> Testicular Swelling | <input type="checkbox"/> Vasectomy? YES/NO If Yes, Date? _____ |
| Other: _____ | |

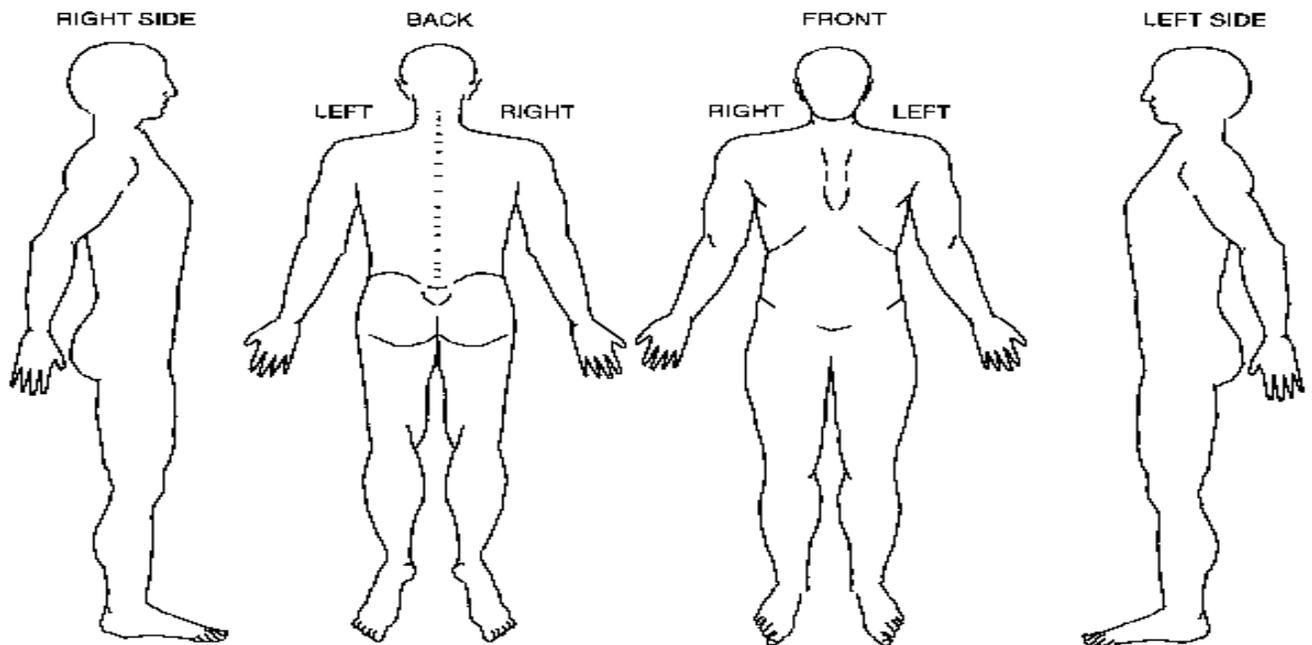
Family History:

Please Check any Illness that run in your Family (Parents/Siblings/Grandparents)

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> High Blood Pressure |

Any significant events in your life that may have impacted you negatively?

Please mark areas of pain, tension or stiffness with a circle:



Nutrition:

Do you follow a special diet? **YES/NO**

If yes, how would you describe your diet (Vegan, Vegetarian, Low Carb etc.)?

What do you eat on a typical day?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Foods you tend to crave: _____

Any other information you'd like me to know before treatment?

Read Before Signing

Patient Confirmation of Consultation with Primary Physician

Alberta Acupuncture Legislation states that an Acupuncturist must not treat someone who has not consulted with a primary care physician or, in the case of dental pathology, a dentist about the condition for which he/she is seeking care and treatment. Therefore, please choose the applicable box confirming that you already have seen a physician, or will be seeing on within two weeks of your first acupuncture appointment.

I have already seen a primary care physician (Western Medical Doctor) regarding the condition(s) that I am seeking treatment for.

I agree to see a doctor regarding my condition(s) that I am seeking treatment for within two weeks of my first acupuncture treatment with Amanda.Zoethout.

Patient Signature

Date (m/d/y)

Patient Waiver and Consent to Acupuncture and Chinese Medicine Treatment

I, _____ (Print Name), have provided to the best of my knowledge, that the above information is complete and correct. I understand that acupuncture treatments are in no way a substitute for examination, diagnosis or treatment by a physician.

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, including but not limited to moxibustion, cupping, TDP lamp, auricular therapy, Tui Na Massage, TCM diet therapy and/or electro acupuncture. I have had an opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand and I'm informed that in practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding, minor bruising, soreness, numbness, infection, nausea,, fainting and stuck/bent needles. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on Amanda Zoethout who has been trained in Clean Needle Technique and who will exercise good judgment during the course of treatment and care provided.

I understand that it is my responsibility to keep the information regarding changes to my medical history current with regards to my condition, medication and any changes in therapies. I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition(s) for which I seek treatment.

I understand that acupuncture is a medical treatment performed by the insertion of single use, sterile needles through the skin to stimulate certain points to regulate "Qi." I hereby authorize Amanda Zoethout to perform acupuncture and have read and understood the potential risks involved. I have been informed that I have the right to refuse treatment and withdraw consent at anytime. I also understand that no guarantee can be made regarding the results of my acupuncture treatment.

Sexual Harassment is taken very seriously. Let it be understood that any illicit, sexually suggestive, inappropriate and/or physical touching of the acupuncturist will result in immediate termination of the session and services at the clinic will be terminated.

I understand that my appointment time has been reserved for my benefit and that if I neglect to give 24 hours notice I will be billed for the full amount of the treatment.

I have read this form carefully and by signing below I am signifying agreement to this consent form.

Patient Signature

Date (m/d/y)