Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

If you need more room, please use the other side of these sheets.

**Chen Weinberg, TCM Acupuncturist, RMT, Shiatsu, Tuina & Reiki**

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_

In Emergency Notify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Complaint (symptoms, diagnosis, duration, etc.)

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**Significant Trauma** (physical or emotional)

**Birth History** (prolonged labour, forceps delivery, complications, etc.)

**Surgeries** (please include date of procedure)

**Allergies** (chemical, environmental, food, drugs, etc.)

**Medications** (names & dosages) Please attach an additional page if necessary.

**Vitamins/Supplements/Herbs**

**Exercise**

Days per week Length of workout Type of Activity

# Diet

Meals per day Snacks Caffeinated Drinks Alcohol per week

**What makes your condition better?** (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

**What makes your condition worse? (**Stress, fatigue, hunger, heat, certain foods, damp days, etc.)

Personal History Please check any conditions or symptoms you have now.

[ ] Arthritis [ ] Liver/Gall Bladder Disease [ ] Stroke [ ] Heart Disease

[ ] High/Low Blood Pressure [ ] Hypo/Hyperglycemia [ ] Kidney Disease [ ] Elevated Blood Cholesterol

[ ] Cancer [ ] Diabetes [ ] Food Allergies/Intolerance [ ] Diverticulitis/IBS

[ ] Ulcer [ ] Seizures [ ] Hepatitis [ ] Raynaud’s Disease

[ ] Chronic Fatigue [ ] Anemia [ ] Thyroid Imbalance [ ] Respiratory Allergies

[ ] Alcoholism [ ] Lyme Disease [ ] Chronic Pain Condition [ ] Impotence

[ ] Gastritis/Pancreatitis [ ] Asthma [ ] Infertility [ ] Emphysema

Family Medical History Please check any condition that applies to your immediate family. Put an F (father),

 M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

[ ] Diabetes \_\_\_ [ ] Seizures \_\_\_ [ ] Heart Disease \_\_\_ [ ] Stroke \_\_\_

[ ] High Blood Pressure \_\_\_ [ ] Allergies \_\_\_ [ ] Cancer \_\_\_ [ ] Asthma \_\_\_

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have had any of these items listed below in the last year

Put a star on the box if you had this in the past but do not any longer.

General

[ ] Poor Appetite [ ] Poor Sleeping [ ] Fatigue [ ] Fevers

[ ] Chills [ ] Night Sweats [ ] Sweats Easily [ ] Tremors

[ ] Cravings [ ] Localized Weakness [ ] Poor Balance [ ] Change in appetite

[ ] Bleed/Bruise easily [ ] Weight loss/gain [ ] Peculiar tastes/smells [ ] Dental/gum problems

[ ] Muscle weakness/fatigue [ ] Sudden energy drop [ ] Strong thirst (hot or cold drinks)

Skin and Hair

[ ] Rashes [ ] Ulcerations [ ] Hives/Allergic Dermatitis [ ] Itching

[ ] Eczema/Psoriasis [ ] Dandruff [ ] Loss of hair [ ] Recent moles

[ ] Skin discoloration [ ] Acne [ ] Change in skin/hair texture [ ] Face flushing

[ ] Dermatitis [ ] Warts [ ] Fungal Infection [ ] Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

[ ] Dizziness [ ] Difficulty swallowing [ ] Migraines [ ] Glasses

[ ] Eye Strain [ ] Eye pain [ ] Poor vision [ ] Night Blindness

[ ] Color Blindness [ ] Cataracts [ ] Blurred vision [ ] Earaches

[ ] Ringing in ears [ ] Poor hearing [ ] Spots in front of eyes [ ] Sinus problems

[ ] Nose bleeds [ ] Recurrent sore throats/colds [ ] Grinding teeth [ ] Facial pain

[ ] Sores on lips/tongue [ ] Dental problems [ ] Jaw clicks/locks [ ] Headaches

Cardiovascular

[ ] Chest pain or pressure [ ] Irregular heart beat [ ] Palpitations at rest [ ] Fainting

[ ] Cold hands/feet [ ] Swelling of hands/feet [ ] Blood clots [ ] Phlebitis

[ ] Shortness of breath [ ] Varicose/spider veins [ ] Pressure in chest [ ] High blood pressure

[ ] Low blood pressure [ ] Spontaneous sweating [ ] Dizziness

Respiratory

[ ] Cough/Wheezing [ ] Coughing blood [ ] Asthma [ ] Bronchitis

[ ] Pneumonia [ ] Pain with deep inhalation [ ] Tight sensation in chest [ ] Difficult inhale/exhale

[ ] Difficulty breathing when lying down [ ] Production of phlegm… what color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal

[ ] Nausea [ ] Vomiting [ ] Diarrhea [ ] Constipation

[ ] Gas [ ] Belching [ ] Black stools [ ] Blood in stool

[ ] Indigestion [ ] Bad breath [ ] Rectal pain [ ] Hemorrhoids

[ ] Bloating/Edema [ ] Chronic laxative use [ ] Loose stools (>2 per day) [ ] Abdominal pain/cramps

[ ] Changes in appetite [ ] Acid reflux/GERD [ ] Hernia [ ] Poor appetite

[ ] Excessive appetite [ ] Significant thirst [ ] IBS/Crohn’s Disease

Genito-Urinary

[ ] Pain on urination [ ] Frequent urination [ ] Blood in urine [ ] Urgent urination

[ ] Unable to hold urine [ ] Kidney stones [ ] Scanty flow [ ] Copious flow

[ ] Impotence [ ] Sores on genitals [ ] Urinary tract infection [ ] Burning urination

[ ] Premature ejaculation [ ] Decreased libido [ ] Prostatitis [ ] Dribbling after urination

[ ] Nocturnal emission [ ] Pain in testicles [ ] Herpes [ ] Infections

[ ] Night urination… What time?\_\_\_\_\_\_ How often?\_\_\_\_\_\_ [ ] Excessive libido

Gynecological/Reproductive

[ ] Difficult/Painful intercourse [ ] Ovarian cysts [ ] Age of first menses\_\_\_\_\_\_\_\_\_

[ ] Vaginal dryness [ ] Endometriosis [ ] Date of last menses\_\_\_\_\_\_\_\_\_

[ ] Vaginal sores [ ] Uterine Fibroids [ ] Date of last PAP/Pelvic\_\_\_\_\_\_\_\_\_

[ ] Vaginal discharge [ ] Fibrocystic breast tissue [ ] Number of pregnancies\_\_\_\_

[ ] Infertility [ ] Polycystic Ovarian Disease [ ] Number of ectopic pregnancies\_\_\_\_\_\_\_

[ ] Irregular menstruation [ ] PMS [ ] Number of live births\_\_\_\_\_\_\_

 [ ] Painful menstruation [ ] Number of miscarriages\_\_\_\_\_\_\_

Do you practice birth control?\_\_\_\_\_\_\_\_ [ ] Number of abortions\_\_\_\_\_\_\_\_\_

What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Musculoskeletal

[ ] Neck pain [ ] Shoulder pain [ ] Hand/wrist pain [ ] Carpal Tunnel

[ ] Knee pain [ ] Sprains/Strains [ ] Sciatica [ ] Foot/ankle pain

[ ] Hip pain [ ] Muscle pain [ ] Muscle weakness [ ] Tendonitis

[ ] Back pain Low\_\_\_ Middle\_\_\_ Upper\_\_\_ [ ] Bursitis [ ] Rotator Cuff

[ ] Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

[ ] Seizures [ ] Loss of balance [ ] Vertigo/Dizziness [ ] Areas of numbness

[ ] Lack of coordination [ ] Poor memory [ ] Concussion [ ] Depression

[ ] Anxiety/Panic attacks [ ] Bad temper/irritable [ ] Easily susceptible to stress [ ] Seasonal Affective Disorder

[ ] Nervousness [ ] ADD/ADHD [ ] Manic Depression

Have you ever been treated for emotional problems? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Have you ever been treated for substance abuse? [ ] Yes [ ] No

Comments Please inform me of any other problems you would like to discuss.

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.*

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. \_\_\_\_\_\_\_\_

 initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. \_\_\_\_\_\_\_\_

 initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. \_\_\_\_\_\_\_\_

 initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. \_\_\_\_\_\_\_\_\_

 initials

To be completed by the patient’s representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship or Authority of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name

Patient’s Signature

Date Signed

Are you Pregnant?

 Chen Weinberg

Name of Licensed Acupuncturist