*360 Wellness Centre Acupuncture*

**CONFIDENTIAL PATIENT HEALTH RECORD**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the following pages so that I can better meet your healthcare needs. If you have any questions, please do not hesitate to ask.

**Reason(s) for Visit: Onset: Frequency: Severity:**

(E.g. Headaches)                (E.g. June 2014)    (E.g. 2x/week) (E.g. Scale 1-10)

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History:**

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries (Major/Minor):**

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**Injuries:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lifestyle Habits:**

**Tobacco:** Y ☐ N ☐    Packs/Day: \_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol:**Y ☐ N ☐    Drinks/Week: \_\_\_\_\_\_\_\_\_\_\_\_

**Other Drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications/Supplements** (present)**:**

**What physical activities do you participate in?**

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**What do you do to relax?**

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**How’s your sleep?** (insomnia, wake up tired, etc.)**:**

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**Major stressors in your life:**

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**Diet** (typical breakfast, lunch, dinner)**:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cravings:**

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**How much water do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How much caffeine do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How is your digestion** (heartburn, nausea, stomach pain, etc.)**?**

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**How are your bowel movements** (diarrhea, constipation, etc.)**?**

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**How often do you have a bowel movement** (per day, per week)**?**

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**How is your urination** (difficulty in, burning pain, frequent, etc.)**?**

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**Cardiovascular Health** (hypotension, hypertension, etc.)**:**

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**Respiratory Health** (asthma, persistent cough, shortness of breath, etc.)**:**

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**Eyes** (floaters, blurry vision, etc.)**:**

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**Ears** (ringing, deafness, infections, etc.)**:**

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**Nose** (chronic congestion, nosebleeds, etc.)**:**

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**Throat** (reoccurring sore throat, difficulty swallowing, etc.)**:**

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**Head** (headaches, TMJ, grinding teeth, etc.)**:**

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**Skin & Hair** (acne, rashes, eczema, hair loss, etc.)**:**

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**Neuropsychological Conditions** (depression, tics, seizures, anxiety, etc.)**:**

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**Indicate where you have pain:**



**X - Sharp**

**D - Dull**

**N - Numbness**

**P - Pins & Needles**

**Women Only:**

**Menstrual History**

**Age of first period: \_\_\_\_\_ Periods Regular: Y** ☐ **N** ☐ **Days between periods**: \_\_\_\_\_

**Duration of Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you bleed between cycles? Y** ☐ **N** ☐

**PMS Symptoms:    None        Before    During    Mid Cycle**

Emotional        ☐        ☐        ☐        ☐

Breast Swelling    ☐        ☐        ☐        ☐

Breast Tenderness  ☐        ☐        ☐        ☐

Back Pain        ☐        ☐        ☐        ☐

Acne            ☐        ☐        ☐        ☐

Headaches        ☐        ☐        ☐        ☐

Bloating         ☐        ☐        ☐        ☐

Cramps        ☐        ☐        ☐        ☐

**Are you using a Contraceptive? Y** ☐ **N** ☐

**What Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of Pregnancies:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Menopausal: Y** ☐ **N** ☐

**Symptoms:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**