ACUPUNCTURE
CONFIDENTIAL PATIENT HISTORY FORM

Name _____
Address _____
City _____
Province _____
Postal Code _____
Home No. _____
Mobile No. _____
Email _____

Occupation _____
Physician _____
Referring Professional _____
Birth Date _____ (Month/Day/Year)

How did you hear about our therapist? _____
How did you hear about our clinic? _____
Have you received acupuncture before? YES ☐ NO ☐
If yes, what was the date of your last visit? _____

PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Stroke
- ☐ Pacemaker
- ☐ Varicose Veins

RESPIRATORY
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Smoking

HEAD/NECK
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss
- ☐ Headaches

INFECTIONS
- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Plantar Warts

WOMEN
- ☐ Menstrual Problems
- ☐ Menopausal
- ☐ Children
  No. of Children _____
- ☐ Pregnant
  Due Date: _____

SKIN
- ☐ Skin Conditions
- ☐ Skin Irritations
- ☐ Bruise Easily

OTHER CONDITIONS
- ☐ Loss of Sensation
- ☐ Diabetes
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis

Please list any medication which you are presently taking: _____
_____

CURRENT CONDITION

Please describe your current condition and symptoms.

_____

_____

_____

How long have you had this condition?

_____

How did it start?

_____

_____

What aggravates it?

_____

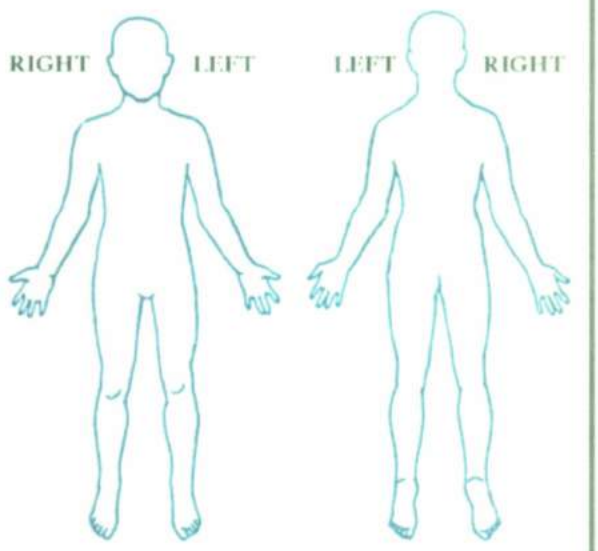
_____

What relieves it?

_____

_____

Please indicate on the diagrams the nature of your symptoms, using the symbols indicated



Aching	OO
Stabbing	XXX
Shooting	>>>>
Burning	##
Numbness	///

Are you currently under another treatment plan with any of the following practitioners?

		Date of Last Visit
☐	Massage Therapist	_____
☐	Chiropractor	_____
☐	Physiotherapist	_____
☐	Naturopath	_____
☐	Acupuncture	_____
☐	Other	_____

NOTES

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