Community Supported Acupuncture

Date:_____

Name:		Gender:	Age:
Address:	City:	Prov:	Postal Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Employer:	Occupation:		
Date of Birth:	Height:	Weight:	Extended health care insurance (company name) :
Emergency Contact:	Contact #:	Relationship:	
Physician:			
How did you find out about us?:	Have you been treated with acupuncture before? ☐ No ☐ Yes ____/____/_____		
Other therapies? What kind? How long?:			

Main Concerns

Please write your top 3 health complaints/concerns in order of importance.

1. _____

When did this start? _____

2. _____

When did this start? _____

3. _____

When did this start? _____

Personal or Family Health History

Please list any history of personal or family illness or chronic condition (e.g. cancer and type, high blood pressure, allergies, etc.).

_____

_____

_____

_____

_____

Habits

Amount/Week

Coffee/Tea _____

Pop/sugar _____

Tobacco _____

Alcohol _____

Drugs _____

Exercise

Do you exercise regularly? ☐ No ☐ Yes

If so, what and how often?:

_____

_____

_____

_____

Diet:

Describe typical eating habits. Please include dietary restrictions and cravings.

Breakfast: _____

_____

Lunch: _____

_____

Supper: _____

_____

Cravings:

_____

Diet restrictions (vegetarian, paleo, etc.):

_____

Medications

Please note what medications, herbs or supplements that you take regularly and for how long.

_____

_____

_____

_____

Injuries & Surgeries

Please note what happened to what body area and date it occurred (incl. dental and car accidents)

_____

_____

_____

_____

Community Supported Acupuncture

In the past month, please mark an X on the spectrum line where your symptoms are, and check any boxes that apply.

Temperature

How warm/cold do you feel (not in degrees); relative to other people? Do you wear more or less layers, etc.

COLD ——— HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

Thirst for cold / hot drinks

- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Usual sweats
  When: _____
- ☐ *Where on body:* _____

- ☐ Hot hands, feed, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

Digestion

DIARRHEA ——— CONSTIPATION

BM: How often? _____x/every _____ days
Stools keep shape? ☐Y ☐N

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas/bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger
- ☐ Dry stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

Energy

LOW ——— HIGH

- ☐ Sudden energy drop
  Time of day: _____
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine/stimulants
- ☐ Wired/ungrounded feeling
- ☐ Body/limbs feel heavy
- ☐ Body/limbs feel weak
- ☐ Shortness of breath
- ☐ Heart palpitation
- ☐ Blood pressure High / Low
- ☐ Bleed/bruise easily
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness/lightheaded
- ☐ Headaches _____x/week

Sleep

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake _____x/night @ _____am/pm
- ☐ Wake to urinate _____x/night
- ☐ Dream-disturbed sleep
- ☐ Restless sleep
- ☐ Not rested upon waking

Emotions

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid/shy
- ☐ Indecision

Eyes, Ears, Nose, Throat

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (*colour* _____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

Urinary

Fluid in = fluid out? ☐Y ☐N

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting/stopping
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Cloudy urine
- ☐ Burning sensation
- ☐ Blood in urine
- ☐ Pain on urination

Women – Menses

Age of first menses: _____
Period lasts _____days
Occurs every _____days
Last menses start date: _____
# of pregnancies: _____

# of births: _____
# of abortions/miscarriages: _____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Cramps
  - ☐ Before bleeding
  - ☐ First day
  - ☐ During period
- ☐ PMS
- ☐ Clots
- ☐ Breast tenderness
- ☐ Fatigue w/ menses
- ☐ Mid-cycle spotting
- ☐ Mood changes
- ☐ Digestive changes w/ menses
- ☐ Yeast infections
- ☐ Birth control (hormonal)
  How long? _____

Women – Menopause

Year changes began: _____
Age of last menses: _____

- ☐ Vaginal dryness
- ☐ Hot flashes _____x/day
- ☐ Night sweats _____x/day
- ☐ Loss of sex drive

Men – Reproductive

Are you sexually active? ☐Y ☐N

- ☐ Change of sex drive? ↑ ↓
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia