ACUPUNCTURE
Confidential Patient History

Name: _____ Date: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Phone Number: _____ Cell Number: _____

Email: _____ Work Number: _____

Occupation: _____ Marital Status (circle) S M W D

Birth Date: _____ Referred by: _____

HSN: _____

What is your reason for consulting our clinic today?:

_____

_____

_____

List any other health problems or concerns you are experiencing:

_____

_____

_____

Please list activites you do on a daily basis (lifting, typing, prolonged sitting/standing)

_____

_____

Circle any of the following conditions that you are PRESENTLY experiencing.

Respiratory:

Chronic Cough
Chest Pain
Difficulty Breathing

Gastrointestinal:

Nausea
Vomiting
Diarrhea

Cardiovascular:

High Blood Pressure
Hardening of the Arteries
Swelling of Ankles

Neurological:

Visual Disturbances
Co-Ordination Difficulties
Dizziness
Slurred Speech
Foot Trouble
Facial Numbness
Difficulty Swallowing

Muscle & Joint:

Stiff Neck
Back Ache
Swolen Joints
Headache
Pain in Shoulders
Spinal Curvature
Faulty Posture

Arthritis
Neck Pain

Please mark any areas of pain on the figures below.