Better Health Clinic

Acupuncture and Traditional Chinese Medicine
Patient Information and Health History

Name: _____ Date: _____(dd/mm/yyyy)

Date of birth: _____(dd/mm/yyyy) Age: _____ Male: ☐ Female: ☐

Address: _____ City: _____ Postal Code:_____

Occupation:_____ # of hours / week: _____

Phone (H): _____ E-mail:_____

Phone(C): _____ Marital status:_____

Emergency Contact:

Name:_____ Phone: _____ Relationship:_____

Main Concern: _____

When/how did it start:_____

What makes it better:_____

What makes it worse:_____

Secondary Concern: _____

When/how did it start:_____

What makes it better:_____

What makes it worse:_____

Additional concerns:

3. _____ 4. _____

5. _____ 6. _____

Have you been examined by another health care practitioner for this condition? Yes No ☐ ☐

If yes, what was the diagnosis? _____

What treatment did you receive? _____

Name of Medical Doctor: _____ Phone # _____

Address: _____

Medications (Please list all medications/herbs/supplements you are currently taking):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Surgery (Please list all past and planned surgeries with dates):

_____

_____

_____

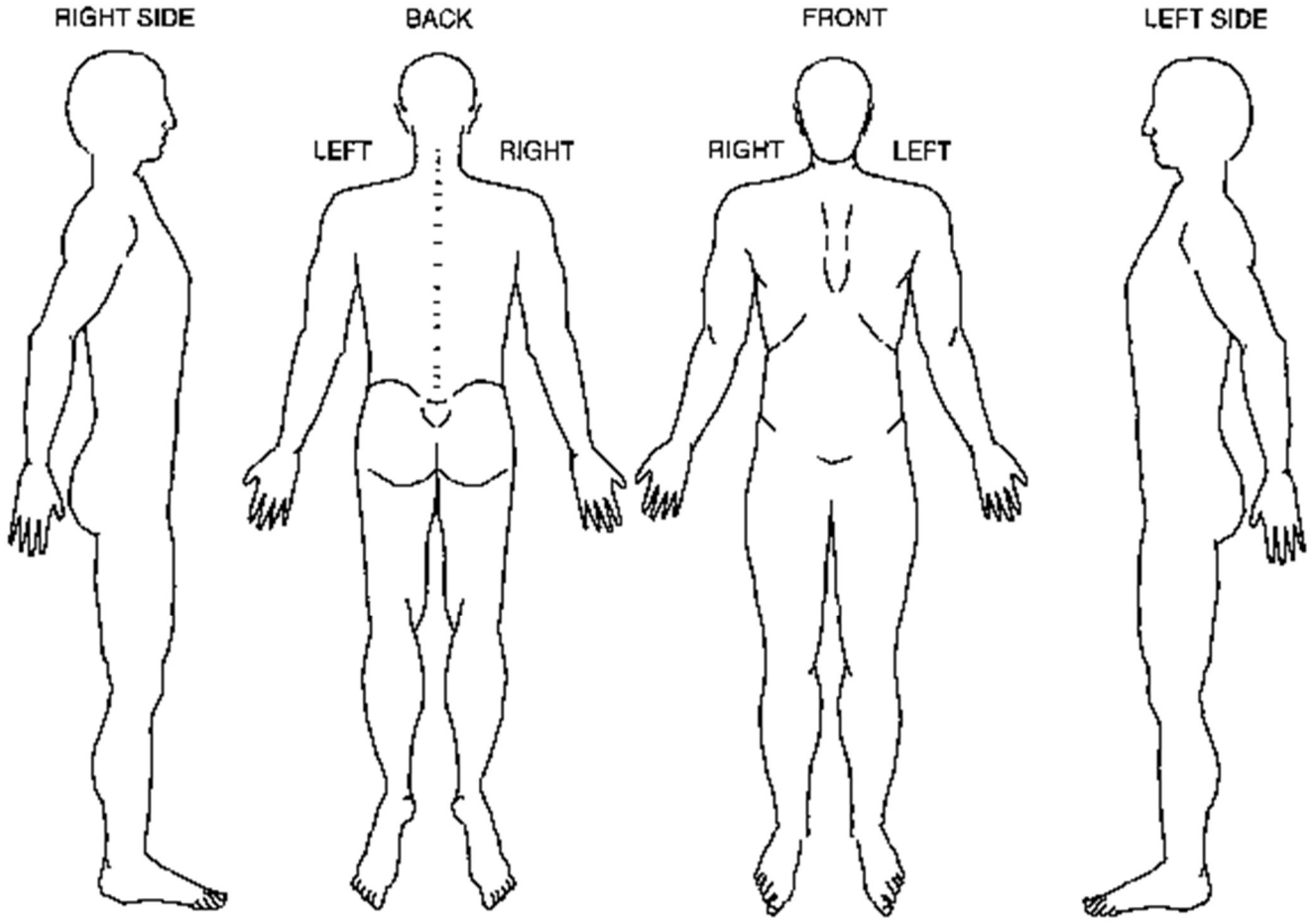
Health History (Please indicate any conditions you have or you had):

- ☐ Allergies
- ☐ Anemia
- ☐ Cancer
- ☐ CFS/Fibromyalgia
- ☐ Depression/Mental Condition
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Disorder
- ☐ Epilepsy/Seizure
- ☐ Heart Disease/Stroke
- ☐ Hemophilia
- ☐ Hepatitis/Liver Disease
- ☐ High/Low Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Skin Disease
- ☐ Thyroid Disease
- ☐ Other:

Pain: If applicable, please indicate the location of pain and type of pain on the diagram below

Legend:

☐ Sharp	☐ Cramping	☐ Dull
☐ Moving	☐ Burning	Other: _____
☐ Fixed	☐ Aching	



Energy & Stress: (Please circle)

Energy Level:	Extremely Low	Low	Average	High
Stress Level:	Extremely High	High	Average	Low

If high please explain your reason: _____

Lifestyle:

Sleep hours per night: _____

Special Diet and/or food sensitivity: _____

Exercise type and frequency: _____

Caffeine/Smoking/Alcohol/Other use and frequency: _____

General Symptoms: (Please check all applicable)

__Fatigue:
__Poor or shallow sleep
__Body heaviness
__Body feels more cold
__Cold hands
__Colds feet
__Water retention/swelling
__Body feels more hot
__Sweats easily
__Overall body aches
__Recent weight gain/loss
__Foggy/cloudy mind

Lung symptoms:

__Cough
__Wheezing
__Shortness of breath
__Chest tightness
__Sinus congestion
__Repeated sore throat
__Swollen glands
__Easily catches colds
__Dry skin
__Cry easily
__Sadness/grief

Kidney symptoms:

__Sore/weak low back
__Sore/weak knee joints
__Low sex drive
__Night sweats
__Hot flashes
__Teeth/hair loss
__Exhaustion
__Fears
__Forgetfulness
__Edema/swelling
__Heat in hands/chest/feet
__Hearing loss
__Tinnitus (ringing in ears)
__Urination problems:

_____

Heart symptoms:

__Insomnia
__Dream-disturbed sleep
__Anxiety
__Palpitations
__Chest pain
__Restlessness
__Mental Confusion
__Mouth/Tongue ulcers
__Poor Memory
__Speech problems:

_____

Liver symptoms:

__Depression
__Moody
__Irritable
__Easily angered
__Frequent sighing
__Repressed emotions
__Numbness in limbs
__Muscle cramps/spasms
__Tics or twitching
__Tight or stiff muscles
__Lump in throat
__Severe migraines/headaches
__Alternating diarrhea/constipation
__Blurry vision
__Emotionally triggered symptoms (headaches, poor digestion, etc)
__Distending pain in chest/ribs
__Eye problems:

_____

Spleen/Stomach symptoms:

__Poor appetite
__Indigestion
__Improper eating habits
__Bloating & gas
__Belching & hiccup
__Loose stool
__Diarrhea
__Constipation
__Abdominal pain
__Muscle weakness
__Bleed or bruise easily
__Worry a lot
__Obscessive thoughts
__Nausae & vomiting
__Acid reflux
__Heart burn
__Ulcers
__Bad breath
__Bleeding gums
__Food cravings:

_____

Women Only:

__Irregular bleeding
__Vaginal discharge
__Currently pregnant
# of weeks: _____
# of past pregnancies ____
# of live births: _____
Due date: _____
__Irregular menstrual cycle
__Menstrual cramps
__Using birth control pills
__Breast tenderness
__Menstrual blood clots
# of days in cycle: _____
Length of period: _____
Other PMS symptoms:

_____

Men Only:

__Swollen testes
__Testicular pain
__Impotence
__Premature ejaculation
__Feeling of coldness or numbness in external genitalia

Better Health Clinic

Informed Consent to Acupuncture Treatment

I, undersigned, understand that Acupuncture and other Traditional Chinese Medicine modalities are safe and effective for the prevention and treatment of wide range of health issues, and the promotion of general health and wellbeing. I understand that acupuncture is not a substitute for conventional medicine and the treatment provided by a medical doctor. I am aware that the acupuncturist does not diagnose illnesses or disease and does not prescribe medications. I am aware that if I want to alter my prescription in any way that I must consult my medical physician.

I have informed the acupuncturist to the best of my knowledge, of all my known physical, emotional and medical histories, conditions and medications and I will update the acupuncturist on any changes.

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following: some pain in the insertion area, minor bruising, light-headedness and fatigue. If I experience any pain or discomfort during the treatment session, I will immediately communicate that to the acupuncturist so that the treatment can be modified.

I understand that there is neither an implied nor stated guarantee of success of effectiveness of a specific treatment or series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I have read the above and hereby request and consent to the performance of acupuncture and other modalities related to acupuncture if necessary including needling, moxibustion, cupping, acupressure and other techniques within the scope of practice of the acupuncturist.

Print Name_____ Date: (dd/mm/yyyy)_____

Signature: _____