Eastern Essence Acupuncture

Patient Name: ______________________________ Date: ______________

Home Address: ______________________________ Postal Code: __________

Phone #: ______________ Work #: ______________

Date of Birth: (MM)____(DD)____(YR)____ Sex: Male ___ Female ___

Were you referred to this clinic? Y__N__ If yes, by whom:__________ ______________

Occupation:________________ Email:______________________________

Medical Doctor: ______________________________ Phone: ______________

Health History – *Please check symptoms you have had in the past year:*

General	Cardiovascular	Genito-Urinary	Men Only
☐ Chills	☐ Diabetes	☐ Frequent Urination	☐ Erectile Difficulties
☐ Depression	☐ Heart Disease	☐ Lack of Bladder Control	☐ Other
☐ Dizziness/Faint	☐ Stroke (TIA)	☐ Painful Urination	
☐ Headaches	☐ Chest Pain		**Women Only**
☐ Fever	☐ High Blood Pressure	**Eye, Ear, Nose, Throat**	☐ Breast lump
☐ Forgetfulness	☐ Low Blood Pressure	☐ Blurred vision	☐ Menstrual Problems
☐ Nervousness	☐ Irregular Heart Beat	☐ Crossed eyes	☐ Hot Flashes
☐ Numbness	☐ Rapid/Slow Heart Rate	☐ Double vision	☐ Other
☐ Sweats	☐ Poor Circulation	☐ Sinus Problems	Date of mammogram:
☐ Sleep Deprivation	☐ Do you smoke?	☐ Asthma	__________
☐ Weight Loss	☐ Varicose Veins	☐ Hay Fever	Are you pregnant?
☐ Arthritis		☐ Hoarseness	__________
☐ Allergies	**Gastrointestinal**	☐ Persistent Cough	
Other__________	☐ Poor Appetite	☐ Difficulty Swallowing	
__________	☐ Bloating	☐ Earaches	**Skin**
	☐ Bowel Changes	☐ Ear discharge	☐ Bruise Easily
Muscle/Joint/Bone	☐ Constipation	☐ Hearing Loss	☐ Hives
Having pain, weakness, or numbness in:	☐ Diarrhea	☐ Ringing in Ears	☐ Itching
☐ Arms	☐ Excessive Hunger	☐ Nosebleeds	☐ Change in moles
☐ Neck	☐ Excessive Thirst	☐ Vision – Flashes/Halo	☐ Rash
☐ Shoulders	☐ Gas	☐ Contact Lenses	☐ Eczema
☐ Upper Back	☐ Indigestion	☐ Headaches	☐ Psoriasis
☐ Lower Back	☐ Nausea/Vomiting	☐ Tension	
☐ Hips	☐ Stomach Pain	☐ Migraines	**General**
☐ Legs	Other__________	Other__________	Date of last Physical:
☐ Knees	__________	__________	__________
			Number of children______
			Other__________

Please list any illnesses or surgeries and their dates ______________________________

____

Please list any accidents and their dates ______________________________

____

Do you bleed or bruise easily? Y___ N___

Do you have any of the following? Please check the applicable boxes

( ) AIDS	( ) Arthritis	( ) Asthma	( ) Cancer
( ) Depression	( ) Diabetes	( ) Stroke	( ) Heart Disease
( ) Kidney Disease	( ) Pace Maker	( ) Epilepsy/Seizures	( ) Thyroid Dysfunction
( ) Hepatitis	( ) Metal Implants	( ) High Blood Pressure	

Are you presently taking any kind of Medications or Nutritional Supplements?
If yes please specify:

Name	Dosage per day	Reason for taking
______________	__________	____________________
______________	__________	____________________
______________	__________	____________________

Are you on anti-coagulant medication? Y___ N___

Allergies: Y N Type:______________________________

Pain: Are you experiencing any pain? Y N Where?____________________
How would you rate your pain from a scale of 0(least) to 10(lots)? Score:__________

Sensation: ( )numbness: where?__________ ( )tingling: where?______________
( )dizziness: how often?__________________ when?______________

Energy Level:
Your energy in general: ( )normal ( )decreased
Concentration / memory: ( )normal ( )decreased
Are you physically active? Y N

Emotional state:
Which of the following emotions do you feel often?
( )sadness ( )grief ( )anxiety ( )worry ( )irritability
( )anger ( )frustration ( )insecurity

Do you experience or have you experienced any of the following in the past month?
Shortness of breath: Y N Palpitations: Y N Pain or tightness in chest: Y N
Swelling? Where______________ Skin problems: Y N Describe:______________

I hereby declare that the above information is correct and that I have not withheld any medical information. I consent to acupuncture/acupressure treatments. I understand that payment is expected at the time of visit, and that if I fail to cancel an appointment **24 hours in advance** I may be charged for the missed appointment. Please be on time for your appointment, arriving late will shorten your actual treatment time.

______________________________ ______________________

Patient's Signature **Date**