Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

If you need more room, please use the other side of these sheets.

Chen Weinberg, TCM Acupuncturist, RMT, Shiatsu, Tuina & Reiki

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Referred by: _____ Occupation: _____

Physician: _____ Phone: _____

Address: _____ City: _____ Province: _____ Postal code: _____

In Emergency Notify: _____ Phone: _____

Main Complaint **(symptoms, diagnosis, duration, etc.)**

Significant Trauma (physical or emotional)

Birth History (prolonged labour, forceps delivery, complications, etc.)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week | Length of workout | Type of Activity

Diet

Meals per day | Snacks | Caffeinated Drinks | Alcohol per week

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (Stress, fatigue, hunger, heat, certain foods, damp days, etc.)

Personal History

Please check any conditions or symptoms you have now.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerance
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis/IBS
- ☐ Raynaud's Disease
- ☐ Respiratory Allergies
- ☐ Impotence
- ☐ Emphysema

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- ☐ Diabetes ___
- ☐ High Blood Pressure ___
- ☐ Seizures ___
- ☐ Allergies ___
- ☐ Heart Disease ___
- ☐ Cancer ___
- ☐ Stroke ___
- ☐ Asthma ___
- ☐ Other_____

Please **check** if you have had any of these items listed below in the last **year**
Put a **star** on the box if you had this in the past but do not any longer.

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor Sleeping
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal Infection
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing
- ☐ Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats/colds
- ☐ Dental problems
- ☐ Migraines ☐ Glasses
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Production of phlegm… what color? _____
- ☐ Bronchitis
- ☐ Difficult inhale/exhale

Gastrointestinal

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation
☐Gas ☐Belching ☐Black stools ☐Blood in stool
☐Indigestion ☐Bad breath ☐Rectal pain ☐Hemorrhoids
☐Bloating/Edema ☐Chronic laxative use ☐Loose stools (>2 per day) ☐Abdominal pain/cramps
☐Changes in appetite ☐Acid reflux/GERD ☐Hernia ☐Poor appetite
☐Excessive appetite ☐Significant thirst ☐IBS/Crohn's Disease

Genito-Urinary

☐Pain on urination ☐Frequent urination ☐Blood in urine ☐Urgent urination
☐Unable to hold urine ☐Kidney stones ☐Scanty flow ☐Copious flow
☐Impotence ☐Sores on genitals ☐Urinary tract infection ☐Burning urination
☐Premature ejaculation ☐Decreased libido ☐Prostatitis ☐Dribbling after urination
☐Nocturnal emission ☐Pain in testicles ☐Herpes ☐Infections
☐Night urination… What time?_____ How often?_____ ☐Excessive libido

Gynecological/Reproductive

☐Difficult/Painful intercourse ☐Ovarian cysts ☐Age of first menses_____
☐Vaginal dryness ☐Endometriosis ☐Date of last menses_____
☐Vaginal sores ☐Uterine Fibroids ☐Date of last PAP/Pelvic_____
☐Vaginal discharge ☐Fibrocystic breast tissue ☐Number of pregnancies____
☐Infertility ☐Polycystic Ovarian Disease ☐Number of ectopic pregnancies_____
☐Irregular menstruation ☐PMS ☐Number of live births_____
☐Painful menstruation ☐Number of miscarriages_____
☐Number of abortions_____

Do you practice birth control?_____
What type?_____ How long?_____

Musculoskeletal

☐Neck pain ☐Shoulder pain ☐Hand/wrist pain ☐Carpal Tunnel
☐Knee pain ☐Sprains/Strains ☐Sciatica ☐Foot/ankle pain
☐Hip pain ☐Muscle pain ☐Muscle weakness ☐Tendonitis
☐Back pain Low___ Middle___ Upper___ ☐Bursitis ☐Rotator Cuff
☐Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

☐Seizures ☐Loss of balance ☐Vertigo/Dizziness ☐Areas of numbness
☐Lack of coordination ☐Poor memory ☐Concussion ☐Depression
☐Anxiety/Panic attacks ☐Bad temper/irritable ☐Easily susceptible to stress ☐Seasonal Affective Disorder
☐Nervousness ☐ADD/ADHD ☐Manic Depression

Have you ever been treated for emotional problems? ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No
Have you ever been treated for substance abuse? ☐Yes ☐No

Comments Please inform me of any other problems you would like to discuss.

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.*

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____
initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____
initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____
initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____
initials

Patient's Name

Patient's Signature

Date Signed

Are you Pregnant?

Chen Weinberg
Name of Licensed Acupuncturist

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient_____

Patient's Representative_____

Relationship or Authority of Patient_____

Witness_____