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.)

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**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 Liver/Gall Bladder Disease Stroke Heart Disease

High/Low Blood Pressure Hypo/Hyperglycemia Kidney Disease Elevated Blood Cholesterol

Cancer Diabetes Food Allergies/Intolerance Diverticulitis/IBS

Ulcer Seizures Hepatitis Raynaud’s Disease

Chronic Fatigue Anemia Thyroid Imbalance Respiratory Allergies

Alcoholism Lyme Disease Chronic Pain Condition Impotence

Gastritis/Pancreatitis Asthma Infertility 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 \_\_\_ Seizures \_\_\_ Heart Disease \_\_\_ Stroke \_\_\_

High Blood Pressure \_\_\_ Allergies \_\_\_ Cancer \_\_\_ 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 Poor Sleeping Fatigue Fevers

Chills Night Sweats Sweats Easily Tremors

Cravings Localized Weakness Poor Balance Change in appetite

Bleed/Bruise easily Weight loss/gain Peculiar tastes/smells Dental/gum problems

Muscle weakness/fatigue Sudden energy drop Strong thirst (hot or cold drinks)

Skin and Hair

Rashes Ulcerations Hives/Allergic Dermatitis Itching

Eczema/Psoriasis Dandruff Loss of hair Recent moles

Skin discoloration Acne Change in skin/hair texture Face flushing

Dermatitis Warts Fungal Infection Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

Dizziness Difficulty swallowing Migraines Glasses

Eye Strain Eye pain Poor vision Night Blindness

Color Blindness Cataracts Blurred vision Earaches

Ringing in ears Poor hearing Spots in front of eyes Sinus problems

Nose bleeds Recurrent sore throats/colds Grinding teeth Facial pain

Sores on lips/tongue Dental problems Jaw clicks/locks Headaches

Cardiovascular

Chest pain or pressure Irregular heart beat Palpitations at rest Fainting

Cold hands/feet Swelling of hands/feet Blood clots Phlebitis

Shortness of breath Varicose/spider veins Pressure in chest High blood pressure

Low blood pressure Spontaneous sweating Dizziness

Respiratory

Cough/Wheezing Coughing blood Asthma Bronchitis

Pneumonia Pain with deep inhalation Tight sensation in chest Difficult inhale/exhale

Difficulty breathing when lying down Production of phlegm… what color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_

Do you practice birth control?\_\_\_\_\_\_\_\_ Number of abortions\_\_\_\_\_\_\_\_\_

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

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name

Patient’s Signature

Date Signed

Are you Pregnant?

Chen Weinberg

Name of Licensed Acupuncturist