Eastern Spirit
ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE

Health History

Date:_____

Name:		Sex:	Age:
Address:	City:	Prov:	Postal Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Employer:	Occupation:		
Date of Birth:	Height:	Weight:	Extended health care insurance (company name) :
Emergency Contact:	Contact #:	Relationship:	
Physician:			
How did you find out about us?:	Have you been treated with acupuncture before? ☐ No ☐ Yes ____/____/_____		
Other therapies? What kind? How long?:			

Main Concerns

Please write your top 3 health complaints/concerns in order of importance.

1. _____
   When did this start? _____
2. _____
   When did this start? _____
3. _____
   When did this start? _____

Personal or Family Health History

Please list any history of personal or family illness or chronic condition (e.g. cancer and type, high blood pressure, allergies, etc.).

_____
_____
_____
_____
_____

Habits

Amount/Week

Coffee/Tea _____
Pop/sugar _____
Tobacco _____
Alcohol _____
Drugs _____

Exercise

Do you exercise regularly? ☐ No ☐ Yes
If so, what and how often?:

_____
_____
_____
_____

Diet:

Describe typical eating habits. Please include dietary restrictions and cravings.

Breakfast: _____
_____
Lunch: _____
_____
Supper: _____
_____
Cravings:
_____
Diet restrictions (vegetarian, paleo, etc.):
_____

Medications

Please note what medications, herbs or supplements that you take regularly and for how long.

_____
_____
_____
_____

Injuries & Surgeries

Please note what happened to what body area and date it occurred (incl. dental and car accidents)

_____
_____
_____
_____

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In the past month, please mark an X on the spectrum line where your symptoms are, and check any boxes that apply.

Temperature

How warm/cold do you feel (not in degrees); relative to other people? Do you wear more or less layers, etc.

COLD ——— HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

Thirst for cold / hot drinks

- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Usual sweats
  When: _____
- ☐ *Where on body:* _____

- ☐ Hot hands, feed, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

Digestion

DIARRHEA ——— CONSTIPATION

BM: How often? _____x/every _____ days
Stools keep shape? ☐Y ☐N

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas/bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger
- ☐ Dry stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

Energy

LOW ——— HIGH

- ☐ Sudden energy drop
  Time of day: _____
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine/stimulants
- ☐ Wired/ungrounded feeling
- ☐ Body/limbs feel heavy
- ☐ Body/limbs feel weak
- ☐ Shortness of breath
- ☐ Heart palpitation
- ☐ Blood pressure High / Low
- ☐ Bleed/bruise easily
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness/lightheaded
- ☐ Headaches _____x/week

Sleep

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake _____x/night @ _____am/pm
- ☐ Wake to urinate _____x/night
- ☐ Dream-disturbed sleep
- ☐ Restless sleep
- ☐ Not rested upon waking

Emotions

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid/shy
- ☐ Indecision

Eyes, Ears, Nose, Throat

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (*colour* _____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

Urinary

Fluid in = fluid out? ☐Y ☐N

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting/stopping
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Cloudy urine
- ☐ Burning sensation
- ☐ Blood in urine
- ☐ Pain on urination

Women – Menses

Age of first menses: _____
Period lasts _____days
Occurs every _____days
Last menses start date: _____
# of pregnancies: _____

# of births: _____
# of abortions/miscarriages: _____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Cramps
  - ☐ Before bleeding
  - ☐ First day
  - ☐ During period
- ☐ PMS
- ☐ Clots
- ☐ Breast tenderness
- ☐ Fatigue w/ menses
- ☐ Mid-cycle spotting
- ☐ Mood changes
- ☐ Digestive changes w/ menses
- ☐ Yeast infections
- ☐ Birth control (hormonal)
  How long? _____

Women – Menopause

Year changes began: _____
Age of last menses: _____

- ☐ Vaginal dryness
- ☐ Hot flashes _____x/day
- ☐ Night sweats _____x/day
- ☐ Loss of sex drive

Men – Reproductive

Are you sexually active? ☐Y ☐N

- ☐ Change of sex drive? ↑ ↓
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia

Consent to Treatment

I, _____, understand that acupuncture and Traditional Chinese Medicine are an energetic forms of therapy based on the regulation of energy and differential diagnosis, and are not intended to replace conventional medical treatment. I assume full responsibility for consulting with the appropriate physician since I understand that any diagnosis of my condition must be performed by a licensed physician.

I hereby authorize Eastern Spirit Acupuncture and Traditional Chinese Medicine to perform the following specific procedures:

- Acupuncture procedures involving insertion of specialized needles through the skin into the underling tissue at specific points on the surface of the body, as well as other techniques such as moxabustion, cupping, electrical stimulation acupuncture, tuina massage, gua sha scraping, and acupressure.
- Herbal and mineral therapies including Traditional Chinese formulas that include plant, mineral and occasionally animal or insect components. I understand that I will receive disclosure of the contents of the herbal formulas and my sensitivities to ingredients will be respected.

I recognize the potential benefits and risks of the above procedures include reactions as described below:

Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energy, which may lead to prevention or elimination of the presenting problem.

Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruises, weakness, fainting, nausea, and even aggravation of symptoms existing prior to the acupuncture treatment. Sensitivities or allergic reactions to herbal remedies, such as nausea or vomiting.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Eastern Spirit Acupuncture regarding cure or improvement of my condition.

I hereby release Eastern Spirit Acupuncture from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time.

Fee:

I understand that fee for treatment is payable at the time of service, and I assume full responsibility for paying Eastern Spirit Acupuncture any money owed for treatment. I understand that I am responsible for seeking reimbursement for treatment from my private health insurance, and an appropriate invoice will be provided for such use.

Missed Appointment:

I will give 24 hours notice if I need to cancel an appointment. I understand without that advance notice, the time reserved for me is my responsibility and will be charged to me as a missed appointment. Missed appointments are charged at the same rates as regular appointments. Insurance companies do not pay for missed appointments so I understand that any appointments missed are my financial responsibility. Exceptional circumstances will be considered regarding this policy.

Signature of Patient	Date
Signature of Person Authorized to Consent	Date