Heart & Hands Community Acupuncture

#6-2020 Douglas St. Victoria, BC V8T 4L1
250-893-2426 www.heartandhandscommunity.ca

Patient History Form and Registration

(mm/dd/yyyy) ___/___/_____

Patient Information

Name _____
Address _____
_____
DOB_____ Occupation_____
Physician _____ Ph # _____

How did you hear about our clinic?

☐ word of mouth ☐ website ☐ walk-by
☐ info session ☐ business card/rack card

Contact Information

Home ph _____Other/cell _____
Email _____

Emergency contact _____
Relationship _____ Ph #_____

If patient is under 16 yrs of age
Parent/guardian _____
Signature _____
Ph # _____ Alt # _____
Witness _____

Main complaints

Please list your main health complaints/concerns in order of importance to you as well as additional information below.

1. _____

MILD 1---2---3—4—5—6—7—8—9—10 SEVERE
Duration:_____
Other treatments:_____
What makes it **better** _____
What makes it **worse** _____

2. _____

MILD 1---2---3—4—5—6—7—8—9—10 SEVERE
Duration:_____
Other treatments:_____
What makes it **better** _____
What makes it **worse** _____

3. _____

MILD 1---2---3—4—5—6—7—8—9—10 SEVERE
Duration:_____
Other treatments:_____
What makes it **better** _____
What makes it **worse** _____

Health History

*Please indicate by the conditions below with an **S** if you have had the condition and the year it started.*
*If there is a family history indicate with an **F**.*

__ Cancer
*type?*_____
__ Diabetes
__ Heart Disease
__ Pacemaker
__ High blood pressure
__ Mental Illness
__ Depression
__ Thyroid condition
Hyper / Hypo
__ Osteoporosis

__ **Bleeding disorder**
__ Anemia
__ **AIDS/HIV**
__ **Hepatitis**
__ Alcoholism/Addictions
__ Stroke
__ Seizure disorder
__ Asthma/Allergies
*type?*_____
__ Autoimmune disease
*type?*_____

Medications *(include herbs or supplements)*

_____
_____
_____
_____
_____

Injuries/Surgeries *(note where on body & when, also include dental)*

_____
_____
_____
_____
_____

How do you sleep? *(trouble falling or staying asleep, dreams, waking often- at specific times, etc.)*

_____
_____
_____
_____

How is your digestion? *(appetite, bowel movements, bloating, nausea, heart burn, etc.)* _____

_____
_____
_____
_____

Body temperature

(Not necessarily in degrees, but how you feel relative to other people- needing to wear more layers, over-heating easily, etc.)

COLDER 1---2---3—4—5—6—7—8—9—10 WARMER

- ☐ Cold hands & feet
- ☐ Easily chilled
- ☐ Numbness location _____
- ☐ Thirst, no desire to drink
- ☐ Never thirsty
- ☐ Always thirsty
- ☐ Hot hands & feet
- ☐ Hot flashes, when? _____
- ☐ Night sweating

Energy level

LOWER 1---2---3—4—5—6—7—8—9—10 HIGHER

- ☐ Drop in energy *time of day* _____
- ☐ Energy drop after meals
- ☐ Needs caffeine/stimulants
- ☐ Shortness of breath
- ☐ Body weakness/heaviness
- ☐ High/low blood pressure
- ☐ Bleed or bruise easily
- ☐ Difficulty focusing
- ☐ Poor memory
- ☐ Dizziness
- ☐ Heart palpitations

Body Moisture (skin, hair, mouth, bowels)

DRIER 1---2---3—4—5—6—7—8—9—10 OILY

- ☐ Dry skin or hair/dandruff
- ☐ Dry eyes
- ☐ Dry/brittle nails
- ☐ Dry nose/mouth/throat
- ☐ Edema/swelling
- ☐ Itchiness/rashes
- ☐ Acne
- ☐ Eczema or psoriasis
- ☐ Oily skin/hair
- ☐ Weight gain/loss
- ☐ Dry stools
- ☐ Mucus in stools

Emotions *(experienced frequently)*

- ☐ Anger
- ☐ Fear
- ☐ Hyperactivity
- ☐ Irritability
- ☐ Sadness/grief
- ☐ Timid/shy
- ☐ Anxiety
- ☐ Depression
- ☐ Indecision
- ☐ Obsessive thoughts

Ear, Nose Throat

- ☐ Vision loss
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Floaters/spots
- ☐ Night blindness *colour*_____
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Cold sores/cankers
- ☐ Phlegm
- ☐ Hearing loss
- ☐ Tinnitus
- ☐ Excess earwax
- ☐ Dental issues
- ☐ Lingering cough

FOR WOMEN ONLY:

Age of 1st menses ___ Date of last menses (dd/mm) __/__
days btwn menses _____ # days of bleeding _____
of pregnancies- births ____ premature ____
# of abortions/miscarriages ____

Bleeding: ☐ heavy ☐ light ☐ irregular ☐ clots
PMS: ☐ Yeast infections ☐ Digestive changes
☐ Breast tenderness ☐ Moodiness ☐ fatigue
Cramping: ☐ before menses ☐ 1st day ☐ during
Contraception type _____
Other symptoms _____
☐ **Menopausal**, *symptoms* _____
_____
_____
☐ **Currently or potentially pregnant**

Welcome to our community. To your health and wellness ☺
The information on this form is accurate to the best of my knowledge:

Signature_____ Date_____