

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	Contact Information		
<p>Name _____ Address _____ _____ DOB _____ Occupation _____ Physician _____ Ph # _____</p> <p>How did you hear about our clinic?</p> <p><input type="checkbox"/> word of mouth <input type="checkbox"/> website <input type="checkbox"/> walk-by <input type="checkbox"/> info session <input type="checkbox"/> business card/rack card</p>	<p>Home ph _____ Other/cell _____ Email _____</p> <p>Emergency contact _____ Relationship _____ Ph # _____</p> <p>*If patient is under 16 yrs of age* Parent/guardian _____ Signature _____ Ph # _____ Alt # _____ Witness _____</p>		
<p style="text-align: center;">Main complaints</p> <p><i>Please list your main health complaints/concerns in order of importance to you as well as additional information below.</i></p> <hr/> <p>1. _____</p> <p style="text-align: center;">MILD 1---2---3—4—5—6—7—8—9—10 SEVERE</p> <p>Duration: _____ Other treatments: _____ What makes it better _____ What makes it worse _____</p> <hr/> <p>2. _____</p> <p style="text-align: center;">MILD 1---2---3—4—5—6—7—8—9—10 SEVERE</p> <p>Duration: _____ Other treatments: _____ What makes it better _____ What makes it worse _____</p> <hr/> <p>3. _____</p> <p style="text-align: center;">MILD 1---2---3—4—5—6—7—8—9—10 SEVERE</p> <p>Duration: _____ Other treatments: _____ What makes it better _____ What makes it worse _____</p>	<p style="text-align: center;">Health History</p> <p><i>Please indicate by the conditions below with an S if <u>you</u> have had the condition and the year it started. If there is a <u>family history</u> indicate with an F.</i></p> <hr/> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> ___ Cancer type? _____ ___ Diabetes ___ Heart Disease ___ Pacemaker ___ High blood pressure ___ Mental Illness ___ Depression ___ Thyroid condition Hyper / Hypo ___ Osteoporosis </td> <td style="width: 50%; border: none;"> ___ Bleeding disorder ___ Anemia ___ AIDS/HIV ___ Hepatitis ___ Alcoholism/Addictions ___ Stroke ___ Seizure disorder ___ Asthma/Allergies type? _____ ___ Autoimmune disease type? _____ </td> </tr> </table> <hr/> <p>Medications <i>(include herbs or supplements)</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <hr/> <p>Injuries/Surgeries <i>(note where on body & when, also include dental)</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	___ 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? _____
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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

- | | | |
|--|---|---|
| <input type="checkbox"/> Cold hands & feet | <input type="checkbox"/> Thirst, no desire to drink | <input type="checkbox"/> Hot hands & feet |
| <input type="checkbox"/> Easily chilled | <input type="checkbox"/> Never thirsty | <input type="checkbox"/> Hot flashes, when? _____ |
| <input type="checkbox"/> Numbness location _____ | <input type="checkbox"/> Always thirsty | <input type="checkbox"/> Night sweating |

Energy level

LOWER 1---2---3—4—5—6—7—8—9—10 HIGHER

- | | | |
|---|--|--|
| <input type="checkbox"/> Drop in energy
<i>time of day</i> _____ | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty focusing |
| <input type="checkbox"/> Energy drop after meals | <input type="checkbox"/> Body weakness/heaviness | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Needs caffeine/stimulants | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Heart palpitations |

Body Moisture (skin, hair, mouth, bowels)

DRIER 1---2---3—4—5—6—7—8—9—10 OILY

- | | | |
|--|--|---|
| <input type="checkbox"/> Dry skin or hair/dandruff | <input type="checkbox"/> Edema/swelling | <input type="checkbox"/> Oily skin/hair |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Itchiness/rashes | <input type="checkbox"/> Weight gain/loss |
| <input type="checkbox"/> Dry/brittle nails | <input type="checkbox"/> Acne | <input type="checkbox"/> Dry stools |
| <input type="checkbox"/> Dry nose/mouth/throat | <input type="checkbox"/> Eczema or psoriasis | <input type="checkbox"/> Mucus in stools |

Emotions (*experienced frequently*)

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Irritability | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Sadness/grief | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Timid/shy | <input type="checkbox"/> Indecision |
| <input type="checkbox"/> Obsessive thoughts | | |

Ear, Nose Throat

- | | | |
|--|---|--|
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Cold sores/cankers | <input type="checkbox"/> Excess earwax |
| <input type="checkbox"/> Floaters/spots | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Dental issues |
| <input type="checkbox"/> Night blindness <i>colour</i> _____ | <input type="checkbox"/> 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 _____