Heart & Hands Community Acupuncture

851 Cormorant St. Victoria, BC V8W 1R2
250-590-3185 www.heartandhandscommunity.ca

Patient History Form and Registration

Patient Information

Name _____
Preferred pronoun _____
Address _____
_____
Occupation_____
Birth date (yyyy/mm/dd) _____/____/____
BC CareCard # __ __ __ __ __ __ __ __ __ __
Physician + ph # _____

How did you hear about our clinic?
□ word of mouth □ online □ walk-by □ flyers

Contact Information

Home ph _____Other ph_____
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 <u>you</u> have had the condition and the year it started.*
*If there is a <u>family history</u> indicate with an **F**.*

__ Cancer
*type?*_____
__ Diabetes
__ Heart Disease
__ Pacemaker
__ Osteoporosis
__ Seizure disorder
__ Stroke/TIA
__ Thyroid condition
Hyper / Hypo

__ **Bleeding disorder**
__ Anemia
__ Mononucleosis
__ **Blood bourne disease**
__ Mental health/addictions
__ Stroke
__ 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 time of day? _____
- ☐ 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
- ☐ Obsessive thoughts
- ☐ Irritability
- ☐ Sadness/grief
- ☐ Timid/shy
- ☐ Anxiety
- ☐ Depression
- ☐ Indecision

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

Gender transitioning, hormonal therapies, surgery
additional info, pls list_____

_____

_____

Menstrual/Hormonal History:

Age of 1st menses ___ Length of cycle (# days) _____

days of bleeding _____

of pregnancies- births ____ premature ____

# of abortions/miscarriages ____ ☐ Cesarian Section

Bleeding: ☐ heavy ☐ light ☐ irregular ☐ clots

PMS: ☐ Yeast infections ☐ Digestive changes ☐ Breast tenderness ☐ Moodiness ☐ fatigue

Cramping: ☐ before menses ☐ 1st day ☐ during

Contraception type _____

☐ Poly-Cystic Ovaries ☐ Hysterectomy

☐ Fertility treatments _____

_____

☐ **Currently or potentially pregnant**

☐ **Menopausal**, *symptoms* _____

_____

_____

_____

Welcome to our community. To your health and wellness ☺

The information on this form is accurate to the best of my knowledge:

Signature_____ Date_____