

## Acupuncture

### Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with an acupuncture treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name \_\_\_\_\_ Email \_\_\_\_\_

We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Street \_\_\_\_\_ Unit \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth (MM-DD-YY) \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_ Last Check-Up Date \_\_\_\_\_

Have you had an acupuncture treatment before?  Yes  No If yes, approximate date of last acupuncture treatment \_\_\_\_\_

Do you see other healthcare practitioners? \_\_\_\_\_

Current Medications \_\_\_\_\_

Previous Major Illnesses/Operations (include dates) \_\_\_\_\_

Allergies/Hypersensitivities \_\_\_\_\_

Major Accidents (include dates) \_\_\_\_\_

Other Serious Medical Conditions \_\_\_\_\_

### What brings you in today?

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**Please check any conditions you are experiencing (past and present):**

**General Symptoms**

- Headaches/migraines
- Fever
- Chills
- Sweat
- Memory loss
- Dizziness/Light headedness
- Fainting
- Stress/depression
- Discoordination
- Nervousness
- Recent weight loss/gain
- Numbness pain in arms, legs

**Respiratory**

- Wheezing
- Chronic cough
- Spitting up phlegm
- Chest pain
- Difficulty breathing

**Muscle and Joint**

- Stiff neck
- Backache
- Swollen joints
- Painful tailbone
- Pain in shoulder
- Hernia
- Spinal curvature
- Faulty posture

- Arthritis
- Foot trouble

**Cardiovascular**

- High or low blood pressure
- Previous stroke or TIA
- High cholesterol
- Swelling of ankles
- Poor circulation
- Stroke/heart attack
- Irregular heart beat
- Shortness of breath
- Pain over heart

**Genitourinary System**

- Frequent/painful urination
- Blood in urine/stool
- Mucus in stool
- Kidney infection/kidney stone
- Bladder infection
- Inability to control urine

**Ears, Eyes, Nose, Throat**

- Hearing loss
- Vision problems
- Glaucoma
- Ringing in ear(s)
- Crossed eyes
- Eye pain

- Deafness
- Earache
- Ear discharge
- Nose bleeds
- Nasal obstruction
- Sore throat
- Hoarseness
- Hay fever
- Asthma
- Dental decay
- Gum trouble
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sinus infection
- Nasal drainage
- Enlarged glands

**Skin**

- Skin conditions/rashes
- Itching
- Bruise easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Hives or allergy

**Gastrointestinal**

- Poor appetite
- Distress from greasy foods

- Excessive hunger/thirst
- Belching or gas
- Nausea
- Vomiting
- Burning in stomach
- Pain over stomach
- Constipation/diarrhea
- Colon trouble
- Liver trouble/hepatitis
- Gall bladder
- Ulcers
- Colitis
- Hemorrhoids
- Hypoglycemia
- Hiatal hernia
- Metallic taste

**For Women Only**

- Cramps/backache
- Previous miscarriage
- Irregular cycle
- Vaginal discharge
- Lumps in breast
- Menopausal symptoms
- Pregnant
- Painful menstruation
- Excessive flow
- Hot flashes
- Hysterectomy

**Have you had any of the following?**

- |                                       |   |  |   |  |
|---------------------------------------|---|--|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Venereal infection | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Pleurisy        |
| <input type="checkbox"/> Malaria      | <input type="checkbox"/> Cold sores         | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Pneumatic fever |
| <input type="checkbox"/> Chicken pox  | <input type="checkbox"/> Whooping cough     | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Rubella         |
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Pneumonia     | <input type="checkbox"/> Influenza      | <input type="checkbox"/> Parkinson's     |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Measles       | <input type="checkbox"/> Gout           | <input type="checkbox"/> HIV/AIDS        |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Polio          |  |

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the Acupuncturist can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and acupuncture treatment at Massothérapie Massage Addict.
- I authorize Massothérapie Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massothérapie Massage Addict clinic if I relocate or a new Massothérapie Massage Addict clinic opens closer to my household.

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

**Updates to your health history are required every 6 months. A new health history form must be filled out every year.**

Changes  Yes  No

Comments \_\_\_\_\_

Signature \_\_\_\_\_

Changes  Yes  No

Comments \_\_\_\_\_

Signature \_\_\_\_\_