Patient History Form – Traditional Chinese Medicine & Acupuncture

Healthy Roots Massage & Wellness Centre
330 Gardiner Park Court Regina, SK S4V 1R9 522-KNOT (5668)

Name:____ Date: ____

Address: ____ Date of Birth (day/month/year): ___/___/____

City: ____________________________ Province: ________________ Postal Code: ____________________

Telephone #: Home (___) _______________ Cell (___) _______________ Work (___) ____________________

Occupation: ____ Email: ____

Emergency Contact: ____________________ Relation: _______________________ Phone #: _________________

Referred by: ____ Physician's Name: ____________________________

Height: ___________________ Weight: _________________

What brings you in today?
Have you ever had acupuncture or herbs before: YES or NO
Are there any other health issues you would like addressed?
Are you currently being treated for a medical condition? Please describe.
Describe what your diet is like:

How is your appetite:
Do you consume: Coffee _______/Day Recreational Drugs_______/Week Alcohol_______/Week Sugar_______/Day Tobacco_______/Day
BODY TEMPERATURE: Are you one to turn up the heat in a room or turn it down? SWEATING: Do you sweat? on exertion spontaneously at night other
Medications/Vitamins you are currently taking:
Allergies:
Briefly describe your weekly exercise:

Are you stressed or relaxed? (Relaxed) 1 2 3 4 5 (Stressed)

What is your energy level? (Low energy) 1 2 3 4 5 (High energy)

PERSONAL HISTORY: Do you currently have, or ever had?

AIDS
Alcoholism
Allergies
Anemia
Appendicitis
Arteriosclerosis
Asthma
Attentions Deficient Disorder
Arthritis
Bleeding Disorder
Bronchitis
Bulimia
Cancer
Candidiasis
Cataracts
Celiac
Chicken Pox
Chronic Fatigue
Chronic Pain
Convulsions
Depression
Diabetes
Eczema
Emphysema
Epilepsy

Gallbladder Problems
German Measles
Goiter
Gout
Heart Disease
Hernia
Herpes
Acute Hepatitis
Chronic Hepatitis
High Blood Pressure
High Cholesterol
Kidney or Bladder Disorder
Liver Disease
Low Blood Pressure
Lupus
Lyme
Measles
Meningitis
Menstrual Disorders
Migraines
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Obsessive Compulsive Disorder

Osteoarthritis
Osteomalacia
Osteoporosis
Parkinson's
Pneumonia
Polio
Prostate Disorders
Psoriasis
Psychiatric Care
Rheumatic Fever
Rheumatoid Arthritis
Seizures
Sexually Transmitted Infection
Stomach or Intestinal Disorder
Stroke
Substance Abuse
Thyroid Disorder
Tonsillitis
Tuberculosis
Ulcers
Urinary Tract Infections

GENERAL

Fatigue
Weakness
Change in Appetite
Low Appetite
Excessive Appetite
Fevers
Chills

Often feel warmer than others
Often feel colder than others
Aversion to wind
Difficulty falling asleep
Difficulty waking
Excessive dreams

Poor memory
Lack of thirst
Strong thirst
Crave sour foods
Crave bitter foods
Crave sweet foods
Crave salty foods

GENITO-URINARY

Painful urination
Unable to hold urine
Frequent urination
Urgency to urinate
Blood in the urine

Cloudy urine
Excessive or scanty urination
Kidney Stones
Bedwetting

Impotency
Decreased libido
Pain/Itching Genitalia
Genital lesions/ discharge

Other:____

HEAD & NECK

Dizziness

Neck Stiffness
Enlarged Lymph glands
Headaches

Jaw tightness/pain
Concussion/Trauma to Head

Other:____

EARS

Ringing in ears
Poor hearing
Earaches

Other:____

NOSE, THROAT & MOUTH

Nose bleeds
Frequent sinus infections

Recurring Sore throats
Seasonal allergies
Grinding teeth

Difficulty swallowing

Other:____

EYES

Blurry vision	Red /Burning Itchy Eyes	Poor Night Vision
Floaters/Spots	Dry Eyes	Cataracts
Tearing	Eye Pain	

RESPIRATORY

Cough	Bronchitis	Frequently catching cold
Cough with blood	Hay fever/Allergies	Difficulty breathing when lying down
Cough with phlegm / Colour:_________	COPD	
Asthma	Pneumonia	
	Sinus Problems	

Other:____

CARDIOVASCULAR

High blood pressure	Palpation/Heart fluttering	Cold Hands/Feet
Low blood pressure	Chest pain/pressure	Swelling of Hands/Feet/Ankles
Blood clots	High Cholesterol	Poor Circulation
Fainting	Irregular heart beat	

Other:____

NEUROLOGICAL

Seizures	Fainting	Numbness/tingling in limbs
Tremors	Migraine	Paralysis
Pain	Concussion	

GASTRO-INTESTINAL

Nausea	Black stool	Alternating Loose/Constipation
Vomiting	Hemorrhoids	Laxative Use: ________/week
Diarrhea	Abdominal Pain/Cramps	Heart Burn/Acid Reflux
Belching	Abdominal bloating	Ulcer
Hiccups	Rectal Pain	Bad Breath
Gas	Constipation	
Blood stool		

Other:____

SKIN AND HAIR

Itching/Dryness
Eczema/Psoriasis
Acne
Bruise Easily
Hives
Rashes
Change in hair/Skin texture
Ulcerations
Hot flashes
Night sweats
Loss of hair
Easily/Spontaneously sweating
Dandruff
Nails break easily
Other:____

MALE

Genital pain
Genital itching
Genital lesions
Genital discharge
Impotence
Erectile difficulty
Premature ejaculation
Lumps on testicles
Low libido
Prostatitis
Weak urine stream

FEMALE

Frequent urinary tract infections
Genital pain
Genital itching
Genital lesions
Genital discharge
Pelvic Inflammatory Disease
Endometriosis
Ovarian Cyst
Uterine Fibroid
Abnormal pap smear
Irregular periods
Abnormal bleeding
Painful menstrual symptoms
Pre-menstrual symptoms
Menopause symptoms
Breast lumps
Infertility
Low libid