

Sinclair Wellness Centre

*** Please note that all information is strictly confidential**

First name: _____ Last name: _____
 Address: _____ City/Postal Code: _____
 Email Address: _____ Cell Phone: _____
 Home Phone: _____ Work Phone: _____
 Date of Birth: _____ Age: _____
 Marital Status: _____ No. of Children: _____
 Occupation: _____ Primary Physician: _____
 Emergency Contact: _____ Phone #: _____
 Extended Health Benefits: Yes NO MSP #: _____

To whom should we thank for referring you to this office: _____

Have you received acupuncture before, and if so, when? _____

Reason for Today's Visit: _____

How, when and where did this condition begin? _____

What types of treatments have you tried, if any? _____

What makes it better? _____

What makes it worse? _____

Please list any other health problems you would like to address in order of importance: _____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, Major Accidents (include dates): _____

Immediate Family Medical History (Mother, Father, Siblings):

Current medications, supplements and vitamins (and what they are for):

Do you currently have or have you ever had any of the following?

- | | | | | | | |
|-------------------------|-----------------|----------------|---------------------|------------|--------------------|------------|
| Anemia | Epilepsy | Fibromyalgia | Arthritis | Diabetes | Multiple Sclerosis | |
| Emotional Disorder | | Drug Problem | Digestive Disorders | | Heart Problem | |
| Pacemaker | Tuberculosis | Cancer | Hepatitis | HIV | Allergies | |
| High/low Blood Pressure | | Kidney Disease | Osteoporosis | Asthma | Stroke | |
| pacemaker | broken bones | herpes | cold sores | psoriasis | eczema | hemophilia |
| Ulcers | Thyroid Problem | Kidney Stones | Gall Stones | Alcoholism | AIDS | |

Other(s) _____

Do you have any drug allergies? _____

Lifestyle:

How are your eating habits? _____

How many meals do you eat on average per day? _____

Have you dieted/cleansed before? _____

Are you a vegetarian/vegan? _____

Do you crave any particular foods? _____

Exercise? Yes No How often? _____ Type? _____

Sleep: Avg. hours per night _____ feel rested in AM? _____

Trouble falling asleep? _____ Easily woken up? _____

Do you get up to urinate more than once at night? _____

Work: Enjoy your work? Yes No Hours per week working _____

Hobbies: _____

Please indicate the use and frequency of the following:

Yes No How Much Yes No How Much

Coffee -

Water -

Tobacco -

Recreational Drugs -

Alcohol -

Soda pop -

Have you ever been a smoker? If so, for how many years?

Symptom Survey (please check all that apply)

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

- | | |
|----------------------------------|---------------------------------|
| 0 1 2 3 4 low appetite | 0 1 2 3 4 ravenous appetite |
| 0 1 2 3 4 loose stools | 0 1 2 3 4 heartburn/acid reflux |
| 0 1 2 3 4 gas/abdominal bloating | 0 1 2 3 4 mouth sores |
| 0 1 2 3 4 fatigue after eating | 0 1 2 3 4 belching or vomiting |
| 0 1 2 3 4 hemorrhoids | 0 1 2 3 4 gums bleeding/swollen |
| 0 1 2 3 4 bruise easily | 0 1 2 3 4 thirst |
| 0 1 2 3 4 anemia | 0 1 2 3 4 bad breath |
-
- | | |
|--------------------------------------|---------------------------------------|
| 0 1 2 3 4 abnormal sweating | 0 1 2 3 4 fatigue |
| 0 1 2 3 4 allergies | 0 1 2 3 4 catch colds easily |
| 0 1 2 3 4 asthma | 0 1 2 3 4 tired after little exertion |
| 0 1 2 3 4 shortness of breath | 0 1 2 3 4 general weakness |
| 0 1 2 3 4 cough | 0 1 2 3 4 nasal discharge |
| 0 1 2 3 4 dry nose/mouth/skin/throat | 0 1 2 3 4 sinus congestion |
-
- | | |
|------------------------------------|---------------------------|
| 0 1 2 3 4 sore, cold or weak knees | 0 1 2 3 4 feel cold often |
| 0 1 2 3 4 low back pain | 0 1 2 3 4 swollen ankles |
| 0 1 2 3 4 frequent urination | 0 1 2 3 4 poor memory |
| 0 1 2 3 4 urinary incontinence | 0 1 2 3 4 hair loss |
| 0 1 2 3 4 ear/hearing problems | 0 1 2 3 4 infertility |
| 0 1 2 3 4 early morning diarrhea | low normal high libido |
-
- | | |
|---|----------------------------------|
| 0 1 2 3 4 irritable | 0 1 2 3 4 muscle spasms/twitches |
| 0 1 2 3 4 ligament/tendon issues | 0 1 2 3 4 numb extremities |
| 0 1 2 3 4 tight feeling in chest | 0 1 2 3 4 dry, irritated eyes |
| 0 1 2 3 4 alternating diarrhea/constipation | 0 1 2 3 4 ear ringing |
| 0 1 2 3 4 sigh frequently | 0 1 2 3 4 anger easily |

0 1 2 3 4 neck/shoulder tension

0 1 2 3 4 red eyes

0 1 2 3 4 feel heart beating

0 1 2 3 4 chest pain

0 1 2 3 4 insomnia

0 1 2 3 4 disturbing dreams

0 1 2 3 4 sores on tip of tongue

0 1 2 3 4 restlessness

0 1 2 3 4 anxiety

0 1 2 3 4 palpitations

0 1 2 3 4 dizzy upon standing

0 1 2 3 4 feeling of heaviness

0 1 2 3 4 see floaters in eyes

0 1 2 3 4 nausea

0 1 2 3 4 heat in palms or soles

0 1 2 3 4 foggy thinking

0 1 2 3 4 afternoon fever

0 1 2 3 4 enlarged lymph nodes

0 1 2 3 4 night sweats

0 1 2 3 4 cloudy urine

0 1 2 3 4 frequently flushed face

Urination: (Circle all that apply)

Burning

Urgent

Scanty

Difficult

Profuse

Dribbling

More than 1x a night

Bowel Movements: Frequency _____Consistency (circle): well-formed hard loose alternates between formed and
loose tenesmus (incomplete feeling) sticky (hard to clean)

Do you ever notice any undigested food, blood or mucous? _____

Are you thirsty? Yes No If so, do you crave warm or cold drinks? _____

Upon waking, do you have a bitter taste in your mouth? _____

Do you find that you typically feel more hot or cold? _____

How is your energy level in general? _____

Do you often get headaches or migraines? Yes No How many per week? _____

How do you feel emotionally right now? _____

Women Only:

Are you currently pregnant? _____ Are you on the birth control pill? _____

How many years have you been on it? _____

Other forms of contraceptives? _____

of pregnancies _____ # of live births _____ # of miscarriages _____ # of abortions _____

How old were you when you had your first period? _____

Have you experienced menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe: _____

Vaginal Discharge? Yes No

Is your period regular? _____ When was the first day of your last period? _____

of days from the start of one period to the start of the next _____

Average number of days of flow: _____ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown Purple

Blood clots? Yes No

Do you get pain or cramps? Yes No Severe? Yes No

Nature of pain (circle): Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your menstrual period?

Water retention Breast tenderness/swelling Depression Irritability Migraines

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

Men Only:

Date of last prostate check up: _____ Results: _____

Circle all that apply: Groin pain Decreased libido Testicular pain Impotence

Painful urination Difficult urination Dribbling urination Incontinence

Premature ejaculation Nocturnal emissions Increased libido

Other: _____

I am committed to your health and well-being. While Chinese Medicine is a very thorough health care system, it is not a replacement for western medical treatment, including regular check ups with your primary care physician.

Patient Signature: _____ **Date:** _____

Practitioner Signature: _____ **Date:** _____

I consent to acupuncture treatment and other procedures associated with Traditional Chinese Medicine. I have discussed the nature of my treatment with my practitioner. I understand that methods of treatment may include but are not limited to: acupuncture, massage, moxibustion, cupping, electric stimulation, and Chinese herbal/dietary medicine. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include pneumothorax and organ puncture. Slight superficial burns are a possible side effect of moxibustion.

I acknowledge that if I do not give 24 hours notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

For MSP claims, I am hard-opt out, meaning that MSP reimbursements are directed to the patient. You will be charged in full for each appointment and reimbursed \$23 from MSP for each appointment after your claim card has been processed.

Patient Signature: _____ **Date:** _____