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Acupuncture, Chinese Herbal Medicine & Herbal Dispensing

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Please bring this completed form to your first visit.

THE FOLLOWING INFORMATION IS STRICTLY CONFIDENTIAL AND IS NOT TO BE RELEASED WITHOUT PATIENTS AUTHORITY

In order to better serve you, we have provided you with the opportunity to complete the required patient information forms prior to your first appointment. Complete the detailed form as best you can. If in doubt, place a question mark in the space provided. Please do your best to provide us with as much information as you can, this will allow us to better treat you.

Your Name:________________________________First Appointment Date:__________________

Date of Birth:________________Occupation_____________________Marital Status___________

Address:____
(street, apartment number)

____Text
(city, town) (state) (postcode)

Telephone number:(residence)__________________________(work)________________________

Mobile:__________________________E-mail:____
(only to be used by this practice)

In Case of Emergency, who should we contact?___________________Mobile:_________________

How did you come to attend this Clinic? Personally referral by______________________________

Referred by Employer:___________________or Yellow Pages Sign Flyer Magazine Other

Your Family Physician:____________________Phone:__________________________________

Physicians Address:____________________________Comments:__________________________

Other Primary Care Givers:____

Other Doctors of Chinese Medicine consulted:____

Do you have a Health Insurance? Yes / No (If yes, give name of fund)______________________

Status: **Private** Pensioner **Veterans Affairs** **Motor Vehicle** **Workers Compensation**

If an accident claim, please give Case Managers Name __________________Phone:_____________

Insurance Claim Number:_________________________Comments:_________________________

What is your level of insurance cover called:________________Can you claim any of the following?

Acupuncture **Herbal Consultation** **Herbal Medicine** **Chinese Herbal Medicine** **Massage**

This clinic sets out to provide a practice, which is relaxing, educating and ultimately personally tailored. In order to do this, we must allocate and limit the number appointments weekly to ensure the best possible care for all. Under these conditions, the clinic reserves the right to charge a **cancellation fee, of fifty dollars** **($55 max)** for any appointment **cancelled with less than twenty-four (24) hours notice, or a fee** **(of $55 per ½ hour booked), for all missed appointments.**

I ___________________________acknowledge that I am personally responsible for the payment of all accounts.

Signed ____________________________Witness__________________

Primary Health Concern

What is your primary health concern ?
How long have you had this condition?
What is your medical diagnosis ?
What is the name of the Physician who made the diagnosis?
When was this diagnosis made?
What specialists have you seen? How has this condition been treated until now?

Are there other areas you would like to see change in your general health? List all other health concerns in order of importance to you. If possible, please indicate the approximate month and year each health concern started. You can list any specific health, fitness or athletic goals you would like to discuss or to be assisted in attaining.

	Health Concerns / Goals	Month / Year	Present Treatment / Comments
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

How long has it been since you experienced excellent health?___________________________________

Please give a detailed history of you primary health concern from when you were first aware there was a health problem through to the present. Include pertinent dates.

____

____

____

____

____

____

____

____

____

____

____

Illness History

Can you see any conections with your present illness or any illnesses you have with any particular, accident, illness, incident, mental upset or unusual stress in your life? If yes, please explain.

___

___

___

___

___

Every disease, serious illness, accident, physical or emotional trauma or drug leaves can guide us to better know your bodies strengths and weaknesses. This will allow your health practitioner to better manage your health.

In the lists below, please circle all the major illnesses you have experienced in your life and indicate next to them the approximate age you were at the time.

GENERAL	RESPIRATORY	CARDIOVASCULAR	SKIN
. allergies . convulsions . dizziness . fatigue . headaches . migraines . fibromyalgia . CFS (chronic fatigue)	. chronic cough . shortness of breath . bronchitis . asthma . emphysema	. high/low blood pressure . chronic congestive heart failure . heart/disease . Blot clots . stroke/CVA . pacemaker fitted	. rashes . sensitive skin . eczema . bruise easily . varicose veins . psoriasis
HEAD/NECK	**WOMEN**	**MEN**	**COMMUNICABLE DISEASES**
. ear problems . vertigo . blurred vision . earaches . vision loss . sinus	. menstrual problems . menopausal problems . infertility .	. prostate cancer . testicular cancer . impotence . infertility	. TB . hepatitis . HIV . Herpes

Other conditions			
• Cancer	• Epilepsy	• Artificial Joints	• Osteoporosis
• Arthritis OA	• Bleeding disorders	• Internal Pins Wires	• Cancer
• Arthritis RA	• Diabetes	• Degenerated Discs	• Thyroid
• ADD	• Depression	• Irritable bowel syndrome	• Bone spurs
• Peptic Ulcer	• Gall Bladder disorder	• Ruptured ear drum	• Cataracts
Please write any other illnesses you have experienced in the spaces below			

Previous or Current Muscle Pain & Tension									
Neck		**Shoulders**		**Arm**		**Leg**		**Back**	
Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
Front	Back	Front	Back	Front	Back	Front	Back	Front	Back

Surgery Accident & Trauma

Please list any Surgeries, accidents and or traumatic events including those both did not and did require treatment.

Also please note any compilations that were as a result of surgery, medications or anaesthesia.

Disease, Surgery, Accident	Age	Duration	Complete recovery?	Treatment (including medication)

Eyes.Ears.Nose.Throat:

Have you experienced any of the following recently (tick or circle).

Dizziness	Eye Strain	Spots in Eyes	Poor Vision
Worn Glasses	Night Blindness	Eye Pain	Cataracts
Blurry Vision	Ear Aches	Colour Blindness	Poor Hearing
Nose Bleeds	Sinus Problems	Ringing in Ears	Dry Throat
Dry Mouth	Copious Saliva	Mucus	Jaw Clicks
Grinding Teeth	Facial Pain	Teeth Problems	Mouth Ulcers
Sores on lips or tongue	Gum Problems	Recurrent sore throats	Laryngitis
Any comments:			

Do you have any comments or questions about your health that you wish to be covered in this session?

Q1 ____

Medications & Immunisations

List all **Prescription drugs** that you are **currently** taking. Indicate present dose and how long you have been taking each medication.

Medication	Dosage	For how long

List all Prescription drugs that you **have taken in your life for periods** ***longer than six months.*** Indicate present dose and how long you took each medication.

Medication	Dosage (if you recall)	For how long

Please comment on any adverse side effects or reactions to any medications.______________________

____

How many times have you been prescribed antibiotics over the last 10 years?______________________

Have you ever been prescribed antibiotics for an extended period of time? Please explain when, why and for how long____

____

Do you use probiotics ("friendly" microflora) following antibiotic use? Y / N

Please indicate your immunizations record:

Type	Anthrax	Cholera	DTP	HAV	HB	Hib
How many times						

Type	Influenza	Measles	MMR	Meningococcal	Mumps	Pertussis
How many times						

Type	Pneumococcal	Polio	Rubella	Tetanus	Typhoid	Varicella
How many times						

Tetanus-Diphtheria (Td) booster within last 10 years? ___/____
(Mo Yr)

Other__________________________Was there any serious reaction to any of the above vaccinations?

(Please give details)____

Food Supplements:

List all of the food supplements you are currently taking. Indicate dosage taken in one day (i.e. if you take two tablets of Vitamin C 500mg/day, total daily is 1000mg).

Type	Dosage	Total per day

Herbal Medications:

List all of the Herbal medications you are **currently** taking.
Indicate dosage taken in one day.

Herb	Mg	Total per day

Known ALLERGIES / Intolerances:____

Known Environmental Allergies / Sensitivities:____

Neuropsychological:

Have you experienced any of the following (tick or circle).

Seizures	Areas of Numbness	Poor Memory	Concussion
Tingling Pins & Needles	Blackouts	Collapses	Loss of Memory
Depression	Anxiety	Bad Temper	Easily Stressed
Treated for Depression	Addiction Withdrawal	Easily Angered	Considered Suicide
Attempted Suicide	Victim of Rape	Victim of Assault	Other

Family History Page 1

What is your position in the family? (Oldest, Middle, Youngest etc.)____________________________

Briefly describe your relationship you're your parents, as a child________________________________

______________________________________as an adult______________________________________

____

How would you describe the health of your spouse?____

Spouses
weight?________________Energy?_________________Emotionally?___________________________

Other ____

Number of children living and any deceased? Living ________Deceased_____________

If any deaths, please state cause of death.____

Family History: ("L" for Living "D" for Deceased. Age is present age or age at time of death.

Relationship	**L / D**	**Age**	**Diseases suffered / Cause of Death**
Mother			
Father			
Maternal Grand Father			
Maternal Grand Mother			
Paternal Grand Father			
Paternal Grand Mother			

Relationship	**L / D**	**Age**	**Diseases suffered / Cause of Death**
Maternal Uncles			
Maternal Aunts			
Paternal Uncles			
Paternal Aunts			
Brother / Sister (1)			
Brother / Sister (2)			
Brother / Sister (3)			
Brother / Sister (4)			
Brother / Sister (5)			
Brother / Sister (6)			

Personal Information: (Please fill in the following, some questions may seem to be repetitive. This is to further ensure your privacy. All of the required information used for administration purposes are gathered on the front page of this form.)

Your Age:________Sex_________Do you have a primary partner Y / N Marital Status____________

Height_______.Present Weight_______Ideal Weight______Do you diet?______________________

Body fat %______Lean Mass %_______Water Content %_________Comments_________________

If your present weight is different to your desired weight, have you ever been that weight. Y / N

If yes, how long has it been since you were that weight?______________________________________

Name of Spouse (if applicable):_________________________Spouses Occupation:_______________

How long have you been married?________________is this your first marriage? Yes _____No______

If you married before, how many times (including this marriage) have you been married?___________

Number of Children? _______________Your occupation (Nature of Work)______________________

Do you enjoy your work_______________________Average Hours worked in a week?____________

Personal Habits & Lifestyle Page 1

Average Time of Starting work___________ Average Time you get home from work_____________

Education Background:____

What hobbies do you have?____

Please indicate your **general diet.**

Non Vegetarian:________________Vegetarian:________Vegan:_________How long:________

Other:____

(Eastern Medicine does not advocate one diet for all people, rather each person must develop one that suits their condition.)

What did you have for Breakfast yesterday? (Time___)____

Breakfast	Time Eaten	
Morning Tea		
Lunch		
Afternoon Tea		
Evening Meal		
Snack		

Is this a usual daily food intake, both in amount, frequency and time of eating? Y / N

Comments____

What is the source of your drinking water?

Tap(city)_________ Bottled (spring)______Filtered______Distilled_______ Well or Tank__________

If filtered what size water filter do you use? _____________(how many micron)Brand?____________

How many cups / glasses do you drink in an average day ? (please give breakdown below)

Coffee	Tea	Herbal Tea	Fruit Juice	Veg Juice
Water	Soft Drink Diet	Soft Drink	Coke	
Full cream Milk	Other	Low Fat	Soy Milk	Goat
Beer	White Wine	Red Wine	Spirits	Other

Do you Smoke tobacco Y / N Have you ever smoked in the past Y / N If yes, for how long _______

If yes, please indicate what products you use and how often you use them?

____

Does anyone in your household smoke? Y / N In the home? Y / N In the car? Y / N

Have you ever used non-prescription drugs? Yes / No (Confidential, if you prefer and not have this information recorded please tell your health practitioner at your consultation.
What types of Drug were they?____

How frequent?____

Do you regularly use (please circle) Laxatives, Sleeping Pills, Antacids, Pain Killers.

If so, please indicate types, frequency and amount:____

____

Personal Habits & Lifestyle Page 2

Have you ever had a problem with an addiction? Y / N

Food_______Alcohol_______Drugs________Other____

How many hours on average do you sleep per night More than 4 5 6 7 8 9 10 11 12

Is your sleep pattern normal at present Y / N

Do you feel refreshed when you wake in the morning _______________Is it hard to get up _________

Do you like to exercise during a normal working week Y / N
Do you like to exercise when on holidays or weekends Y / N

If you exercise regularly, what do you do (please specify frequency, intensity and duration)

____

____

____

What do you do for recreation? ____

When was your last holiday? ____

How would you describe your present level of personal stress? (tick or circle)

Minimal	Average	Considerable	Unbearable

What is the main stress in your life? (tick or circle)

Job Related	Financial	Marriage	Health
Family Members	Expectations	Interpersonal	Spiritual

Comments____

Food Cravings / Desires / Aversions:

Please indicate in the following boxes areas of “Like” “Dislike” or if the food makes you feel unwell.

You **can put more than one tick to emphasise** areas that you strongly like or dislike.

Food / Flavour	Like	Dislike	Not for me	Food / Flavour	Like	Dislike	Not for me
Pungent				**Bitter**			
Garlic				Turnips			
Cloves				Coffee			
Ginger				Asparagus			
Chilli				Radish			
Pepper				Alfalfa			
Salty				**Sweet**			
Seaweeds				Sweet Potato			
Soy Products				Dates			
Pickles				Peas			
Gomasio				Carrots			
Miso soup				Peaches			
Sour				**Cucumber**			
Vinegar				Oysters			
Pickles				Egg Plant			
Lemons				Capsicum			