

Riverside Acupuncture & Wellness Centre

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Phone: (613) 863-6906

Date _____

Personal Information

Name _____ Date of Birth ____/____/____ Age _____

Gender: Male / Female Height _____ cm Weight _____ kg Marital Status _____

Phone (H) (_____) _____ - _____ Phone (W) (_____) _____ - _____

Phone (Cell) (_____) _____ - _____

Address _____

City _____ Province _____ Postal Code _____

E-mail _____

Employer _____ Occupation _____

Family Physician _____ Phone (_____) _____ - _____

Referred by _____ Phone (_____) _____ - _____

Confidential Patient Health History

Chief Complaint(s) *What kind of problem do you have?*

Other Complaint(s)

What kinds of treatments have you received? _____

Medications being taken _____

Allergies _____

Do you have or are you any of the following?

- Pacemaker Electric Implants Metal Implants Severe Bleeding Disorders
 Pregnant HIV Positive Hepatitis A/B/C

How did you know about Riverside Acupuncture & Wellness Centre?

- Tone Magazine Brochure/Flyer displayed From families/friends Internet
 Local papers Others: _____

Please check or answer in BOLD if you have had (in the past three months):

General

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Strong Thirst (hot or cold drinks) | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sudden Energy Drop | <input type="checkbox"/> Tetanus Shot |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Poor Sleep Habits | <input type="checkbox"/> Frequent cold/flu |

Skin and Hair

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Open sore | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Acne | <input type="checkbox"/> Loss of Hair |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Corns | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Warts | <input type="checkbox"/> Nail Problems |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Eczema | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Headaches | | |

Cardiovascular

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Myocarditis | <input type="checkbox"/> Coronary Heart Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Pneumatic Heart Disease | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hardening of Arteries |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Mitral Stenosis | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Mitral Prolapse | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet |

Respiratory

- | | | |
|--|---|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain w/ deep breath |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Production of Phlegm |
| <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Emphysema | | |

Gastrointestinal

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Abdominal Pain or Cramps | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Colitis | |

