



First Chiropractic & Wellness Clinic  
 624-1st Avenue NW  
 Moose Jaw, SK  
 S6H 3M6

## Acupuncture Patient Information Sheet

### Confidential Patient History

Date: \_\_\_\_\_

### INITIAL INFORMATION

Name: \_\_\_\_\_

Sex: M/F

Email: \_\_\_\_\_

May we contact you by email? yes/no

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Birth Date (month/day/year): \_\_\_\_\_

Who may we thank for referring you to our clinic? \_\_\_\_\_

### **PERSONAL HEALTH HISTORY**

Have you had previous acupuncture care? Yes/No When? \_\_\_\_\_

List any known allergies: \_\_\_\_\_

Do you smoke? Yes/No If yes, how many cigarettes/day? \_\_\_\_\_

Do you consume alcohol? Yes/No If yes, how many drinks/week? \_\_\_\_\_

Please list any significant previous injuries (fractures, sprains, motor vehicle accidents, etc.): \_\_\_\_\_

Please list any surgeries you have had and when you had them: \_\_\_\_\_

Please list any health conditions you presently have or have had in the past (e.g. cancer, anemia, arthritis, epilepsy, stroke, hepatitis, HIV/AIDS, diabetes, etc.): \_\_\_\_\_

Do you have any local infections or elevated risk of infections? Yes/No

Do you have a pacemaker or any other electrical/metal implants? Yes/No If yes, where? \_\_\_\_\_

Have you ever had any radiographs/x-rays taken? Yes/No

Where? \_\_\_\_\_ When? \_\_\_\_\_ Results? \_\_\_\_\_

Are you, or is there a chance that you may be pregnant? Yes/No

Do you have any current or previous blood disorders (e.g. high blood pressure, blood clotting problems, infections, etc)? Yes/No

How many days per week do you exercise? 0 1 2 3 4 5 6 7

How many servings of each food group do you get per day? Meats \_\_\_\_\_ Fruit/Vegetable \_\_\_\_\_ Grain/Pasta \_\_\_\_\_ Dairy \_\_\_\_\_

How many hours do you normally sleep per night? 1 2 3 4 5 6 7 8 9 10 11 12

### **FAMILY HISTORY**

Please indicate any health conditions regarding your:

Spouse/Partner: \_\_\_\_\_

Siblings: \_\_\_\_\_

Mother/Father: \_\_\_\_\_

Children: \_\_\_\_\_



**CHIEF COMPLAINT**

Briefly describe your current complaint or reason for your appointment: \_\_\_\_\_

When did your condition initially begin? \_\_\_\_\_

Cause of condition (please circle all that apply): motor vehicle accident, work related injury, sudden trauma, reoccurrence, repetitive trauma, unknown, other: \_\_\_\_\_

What makes the condition feel better? \_\_\_\_\_

What makes the condition feel worse? \_\_\_\_\_

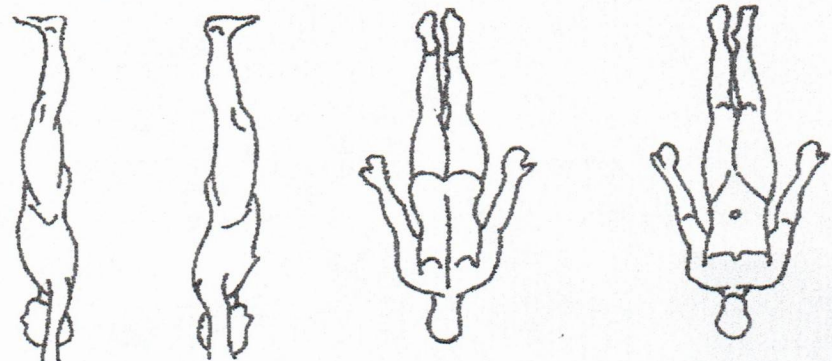
Does coughing or sneezing aggravate your pain? Yes/No \_\_\_\_\_

Do you have any loss of control with bowel or bladder function? Yes/No \_\_\_\_\_

Do you currently have a fever? Yes/No \_\_\_\_\_

Please use the following drawing to mark the area(s) where you feel the described sensations. Use the appropriate symbol.

**LEGEND:**  
 A = ACHE  
 P = PINS & NEEDLES  
 B = BURNING  
 S = STABBING  
 N = NUMBNESS  
 O = OTHER



Use the scale below to indicate your level of pain today (T), and in general (G):

(0 = no pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (10 = worst pain)

What is your energy level (please circle)? Low 1 2 3 4 5 6 7 8 9 10 High

What is your stress level (please circle)? No stress 1 2 3 4 5 6 7 8 9 10 High stress

Mark the treatments that you have received so far for your pain/fatigue or other problems?

- Relaxation
- Physical Therapy
- Chiropractic
- Massage Therapy
- Naturopathy
- Medication

Other Treatments (please specify): \_\_\_\_\_

So far, which treatments have benefited you the most? \_\_\_\_\_

Please list all of the medications and supplements you are taking and the conditions you are taking them for: \_\_\_\_\_

What are your treatment goals and expectations from acupuncture? \_\_\_\_\_

**NO SHOW/LATE CANCELLATION POLICY:** As a courtesy to other patients and the doctor, we ask that you give us a 24 hour notice if you cannot make it to your scheduled appointment. Our policy is to charge for missed appointments at the rate of the scheduled visit, billed directly to you, and payable prior to your next visit. SGL, FHB and WCB do not cover the cost of a missed appointment. Please help us to serve you better by keeping scheduled appointments. Thank you.

I have read, understood and agree to the above financial policy.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_