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

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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: _____