**Guelph Community Acupuncture**

# New Patient Form

CONFIDENTIAL

| | | | |
|---|---|---|---|
| Name: | | | Date: |
| Date of birth: | Age: | Phone: | Cell: |
| Pronoun preference? *(If your name and/or pronoun changes, we're happy to adjust)* | | | |
| Address: | | | Postal Code: |
| Email: | | | Occupation: |
| Emergency Contact (name and phone): | | | |
| How did you hear about us? | | | Shall we include you in our very low traffic (about once per month) email newsletter? Y ☐ N ☐ |

## Main Concerns

***(please only include as much information as you feel comfortable sharing)***

❶ _____

When did this start? _____

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Damp weather: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild) ⊢——⊢——⊢ 10 (severe)

❷ _____

When did this start? _____

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Damp weather: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild) ⊢——⊢——⊢ 10 (severe)

❸ _____

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1 (mild) ⊢——⊢——⊢ 10 (severe)

## Health History

| | Past | Now | | Past | Now |
|---|---|---|---|---|---|
| Cancer Type: | ☐ | ☐ | Allergies Type: | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Dizzy/fainting | ☐ | ☐ |
| Blood Pressure high ☐ low ☐ | ☐ | ☐ | Thyroid high ☐ low ☐ | ☐ | ☐ |
| Heart disease | ☐ | ☐ | Blood disorder | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Liver disease | ☐ | ☐ | AIDS/HIV | ☐ | ☐ |
| Asthma | ☐ | ☐ | Other STI | ☐ | ☐ |
| Seizures | ☐ | ☐ | Headaches | ☐ | ☐ |
| Addiction | ☐ | ☐ | Back pain | ☐ | ☐ |
| Type: | | | Mental illness Type: | ☐ | ☐ |

**Medications**

Please note any drugs or supplements you take regularly

Do you exercise regularly?

Y ☐ N ☐

Type?

| Habits | Amount |
|---|---|
| Sugar | |
| Caffeine | |
| Tobacco | |
| Alcohol | |

**Serious Injuries & Surgeries**

What, When

## Digestion

Loose ⊢——+——⊣ Hard

BM: How often?
____ every ___ days
☐ IBS
☐ Blood in stools

☐ Gas/bloating
☐ High appetite
☐ Poor appetite
☐ Nausea

☐ Indigestion
☐ Bad breath
☐ Heartburn
☐ Belching

☐ Dry stools
☐ Difficult to pass
☐ Foul smelling
☐ Hemorrhoids

## EENT

☐ Poor vision
☐ Red eyes
☐ Itchy eyes
☐ Sinus congestion
☐ Phlegm
☐ Cough
☐ Sore throat
☐ Poor hearing
☐ Ear ringing
☐ Dental problems
☐ Mouth sores
☐ TMJ
☐ Grind/clench teeth

## Emotions

☐ Anger
☐ Irritability
☐ Anxiety
☐ Obsessive thinking
☐ Grief
☐ Depression
☐ Easily excitable
☐ Easily startled
☐ Panic attacks

## Stress

Low ⊢——+——⊣ High

## Sleep

# hours per night _____
☐ Trouble falling asleep
☐ Wake ___x/ night
When?
☐ Wake to urinate
How often?
☐ Disturbing dreams
☐ Restless sleep
☐ Don't feel rested

## Reproductive Health

☐ Change of sexual drive (↑ / ↓)
☐ Infertility
☐ Endometriosis
☐ Fibroids
☐ Hysterectomy
☐ Prostate problems
☐ Erectile dysfunction
☐ Premature ejaculation
☐ Candida

## Urinary

☐ Decreased flow
☐ Dribbling
☐ Incontinence/ urgency
☐ Increased frequency
☐ Kidney/Bladder stones

☐ Pain on urination
☐ Burning
☐ Cloudy
☐ Blood in urine

## Menses

Are you/ could you be pregnant?
Y ☐ N ☐
Are you trying to get pregnant?
Y ☐ N ☐
Last period start date: ____/____
Duration of bleeding: ____
Length of cycle: ____
# of pregnancies: ____
# of births: ____

☐ Heavy periods
☐ Light periods
☐ Irregular periods
☐ Cramps
  ☐ before
  ☐ first day
  ☐ during
☐ Clots

☐ Mood changes
☐ Fatigue
☐ Sleep changes
☐ Digestive changes
☐ Bloating
☐ Cravings
☐ Mid-cycle spotting
☐ Yeast infections
☐ Chest tenderness
☐ Low back ache

## Menopause

Age of last menses: _____
Year changes began: _____
☐ Hot flashes
☐ Night sweats
☐ Vaginal dryness
☐ Other (please describe):