Confidential Case History

We are pleased that you have come to us regarding your overall health. This information is essential for the diagnosis procedure and helps us to provide you with a better treatment. Please complete this form as accurately as you can. Please ask for assistance if needed.

Legal Name: _____

Address: _____City:_____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred phone number to leave messages: ____ home ____ work _____ cell

E-mail: _____
(you will receive important information on your care and appointment confirmation to this address)

Birthdate (DD/MM/YY): _____

Occupation: _____

Type of Work: _____Hours Work/Study /week: _____Computer hours /day: _____

Medical Doctor's Name: _____

How did you hear about us? _____

Emergency Contact (name/phone #/relationship to you): _____

Your Health Profile:

If you have no symptoms or complaints and are here for wellness services, please check here ___, and move to section B below.

A) Reason for attending our office: _____

Location: _____

Describe issue: _____

Have you had this or similar condition in the past? ___ Yes ___ No Is the pain local or radiating (circle)?

On a scale of 1 to 10 (10 being worst), please rate pain: _____ today _____ at its best _____ at its worst

Aggravated by? _____ Relieved by? _____

Is this condition getting worse? Yes No Constant Comes and Goes

Other treatments tried for this condition? _____

What has been diagnosed (By M.D.)? _____

B) Have you had previous acupuncture care? Yes No

Where? _____ When? _____

Why? _____

C) Medical History:
Pregnancies?
Any problems during your birth?

List any medication you are taking and why:

List any supplements/vitamins you are taking and why:

List any Childhood illnesses / surgeries / accidents and age:

List any Adolescence illnesses / surgeries / accidents and age:

List and Adult illnesses / surgeries / accidents and age:

List any pain you have in your body, including muscle aches and pains:

◯ **Circle** any problems, disease, or symptoms you currently have. **<u>Underline</u>** items that affected you in the past:

Skin:	eczema	acne	skin rashes	dermatitis	furuncles
	warts	psoriasis	fungal infections		

Heart and Vascular:

fast pulse (>100)	slow pulse (<60)	palpitation	irregular pulse	
shortness of breath	chest pain	dizziness	flushed face	
cold hands	cold feet	Raynaud's disease	feeling of pressure in the chest	
anemia	high blood pressure	low blood pressure	migraine headache with nausea	
cold sweats	red face	feel dizzy/ faint when standing up quickly		

Gastrointestinal:

constipation	diarrhea	stomach pain	indigestion	no appetite
heartburn	intestinal gas	belching	ulcer	gastritis
lack of stomach acid	hemorrhoids	peritonitis	polyps	pancreatitis
ileocecal valve spasm	GI tumors	irritable bowel		

Respiratory:	cough	wheeze	asthma	bronchitis	emphysema
	pneumonia	lung abscess	difficulty breathing		

Hormonal Imbalance:

Diabetes	hypoglycemia	hypothyroidism	hyperthyroidism
Other hormone imbalance: _____			

Male:	vasectomy	impotence	premature ejaculation	prostate gland issues	infertility

Female:	menstrual problems	cramping	heavy / light/ irregular periods
	emotional reactions	menopause symptoms	PMS
	infertility	low libido	cysts

Autoimmune & Inflammatory Conditions:

Hashimoto's Disease (thyroid)	rheumatism	Lupus	colitis	Crohn's disease
alopecia	allergy	food allergy	sinus allergy	neurodermatitis
atopic dermatitis cellulitis	low immunity	HIV	AIDS	hepatitis

Ear, Nose & Throat:

deafness	tinnitus	itchy ear	ear pain
frequent ear infections	sinus headaches	stuffy nose	post-nasal-drip
dry throat	strep infections	sore throat	dry eyes
glaucoma	vision issues		

Oral Disease:	bleeding gums	periodontitis	dental abscess
mumps	stomatitis	TMJ	toothaches without cavities

General:	insomnia	weakness	exhaustion
depression	anger	irritable	anxiety
difficult concentration	unusual sweating	no sweat	PTSD

D) Lifestyle:

Poor Posture: Yes No
Extensive Computer Work: Yes No
Repetitive Lifting: Yes No
Continuous Sitting: Yes No
Smoker – Amount: Yes No Daily ( )
Second-Hand Smoke: Yes No
Poor Diet: Yes No
Caffeine – Amount: Yes No Amount ( ) cups/day
Excessive Sugar / Soda: Yes No
Artificial Sweeteners /Diet Foods: Yes No
Non-prescription Drugs: Yes No
Over-The-Counter Drugs (Tylenol, Advil, etc): Yes No Daily ( ) Weekly ( )
Alcohol Consumption: Yes No Daily ( ) Weekly ( )
Hours of Sleep per night:
Current Exercise Levels:

E) Family History:

Please note all major illnesses in your immediate family:

F) Goals:

Imagine you could wish for 5 things to change about your health in the year to come. What would it they (think big!). What would you do that you currently feel you can't do?

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Date:

Print Name

Signature

Name of Parent or Guardian

Signature of Parent or Guardian

HEALTH RESULTS INC.
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Calgary, AB T2T 1Z6
michelle@healthresults.ca

INFORMED CONSENT FOR ACUPUNCTURE AND CHINESE MEDICINE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures. I understand that such procedures may include but are not limited to acupuncture, moxibustion, cupping, gua sha, infrared heat lamp, electrical stimulation, Chinese herbal medicine, Tui-Na, exercise and stretching therapy, and nutritional advice based on traditional Chinese medical theory.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, infection, numbness or tingling, dizziness or fainting, minor swelling, bleeding, and hematoma may occur at the site of insertion that may last a few days. Unusual risks of acupuncture may include spontaneous miscarriage, nerve damage and organ puncture. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that Chinese herbs may be recommended to me. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs or acupuncture treatments may not be appropriate during pregnancy. I will notify the acupuncturist or clinical staff member if I have any unwanted side effects from taking herbs or if I am or become pregnant.

I have been informed that in all acupuncture treatments only sterile, one time use, disposable needles are used according to the Clean Needle Technique protocol, and that the acupuncturist will maintain a clean and safe environment to ensure the safest acupuncture treatment possible.

I understand that at any time before or during treatment I may ask questions and that at any time I may stop treatment if I become uncomfortable. I also understand that acupuncture is not a replacement for a Western Medical diagnosis and that I should consult with my Western medical doctor.

I understand that the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I am aware that acupuncture is not a guaranteed form of treatment, nor is it a substitute to Western Medical treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Date:_____

_____	_____
Print Name of Patient	Signature of Patient
Michelle Greenhough, B.Sc., R.Ac.	_____
Acupuncturist	Signature of Acupuncturist
_____	_____
Parent/Guardian	Signature of Parent/Guardian