ACUPUNCTURE PATIENT PROFILE

TITLE		FIRST NAME		SURNAME	

ADDRESS			
		POSTCODE	

DATE OF BIRTH	__ __/__ __/__ __ __ __	EMAIL	

MOBILE NO.		WORK NO.		HOME NO.	

REASON FOR VISIT - List health complaints and their duration (if more than one then list the most serious first)

1
2
3
4
5

MEDICAL HISTORY - List any major illness and age of occurrence

List any surgery or injuries and age of occurrence

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FAMILY MEDICAL HISTORY - List any major illness and age of occurrence

LIST YOUR VITAMINS AND SUPPLEMENTS

CURRENT MEDICATION - List all current medication and reason for taking? How long you have taken them.

How many courses of antibiotics have you taken in the last 3 years & for what reason?

____

How do you rate your energy levels? (please circle a number) LOW 1 2 3 4 5 6 7 8 9 10 HIGH

How do you rate your stress levels? (please circle a number) LOW 1 2 3 4 5 6 7 8 9 10 HIGH

What sort of exercise do you do? How often per week?

How much alcohol do you drink per week?_________________________ Coffee per week?________ Cigarettes per week? ____________

What other fluids do you drink daily and how often?____

How is your blood pressure? (please circle) HIGH NORMAL LOW

Do you suffer from any type of cardiovascular problems? NO / YES (please describe below)

DIGESTION

How is your appetite? (please circle) EXCESSIVE GOOD POOR VARIABLE

Are you allergic or suspect you are intolerant to any foods, chemicals or any other substances (dust mites, moulds, seafood, dairy, wheat, etc?)

DIET

What do you usually eat for

Breakfast	
Lunch	
Dinner	
Snacks	

FOR WOMEN ONLY (PLEASE ANSWER THE QUESTIONS IN THE BOX)

Have you in the past or are you currently taking the pill? If yes, then how many years and for what reason?

____

How many days in your bleed? ____________ How many days is your cycle? ___________ Any clotting? ______________________________

Please describe your period (colour, amount of flow etc.) ____

Have you experienced any of these symptoms? Please tick

✓ once or twice in the past

✓✓ occasionally

✓✓✓ frequently

-------- Urinary tract infections

-------- Thrush or vaginitis

-------- Ovarian cysts

-------- Polycystic ovaries

-------- Fibroids

-------- Menstrual cramping

-------- Irregular periods

-------- Infertility

-------- Breast lumps

-------- Positive pap smears

-------- Vaginal discharge

-------- Endometriosis

-------- Miscarriage

-------- Termination

How many children do you have and how old are they? ____

DO YOU EXPERIENCE ANY OF THESE SYMPTOMS? Please tick

✓ if you have had the symptom once or twice in the past, but it doesn't bother you now

✓✓ if you occasionally experience this symptom

✓✓✓ if you frequently experience this symptom

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UNDERLINE & TICK if you don't normally suffer this symptom but it is currently bothering you.

-------- Digestive problems
-------- Bloating
-------- Indigestion
-------- Belching
-------- Acid reflux
-------- Heartburn
-------- Abdominal pains/cramps
-------- Bad breath
-------- Mouth ulcers
-------- Stomach ulcers
-------- Nausea
-------- Flatulence
-------- Loose stools
-------- Diarrhoea
-------- Constipation
-------- Mucous/ blood in stools
-------- Worry
-------- Bruise easily

-------- Frequent colds or flus
-------- Sinus/rhinitis/hay fever
-------- Shortness of breath
-------- Cough
-------- Asthma
-------- Tightness in the chest
-------- Grief/sadness

-------- Hearing loss
-------- Aversion to cold weather
-------- Low back ache or stiffness
-------- Fluid retention
-------- Frequent or nocturnal urination
-------- Thyroid problems

-------- Cold hands & feet
-------- Muscle cramps
-------- Ringing in ears
-------- Migraines or headaches
-------- Herpes Simplex
-------- Gallstones
-------- Poor vision
-------- Dizziness
-------- Anaemia
-------- Dry itchy eyes
-------- Spots floating in your vision
-------- Skin problems
-------- Depression
-------- Irritability/frustration

-------- Night sweats
-------- Heart palpitations
-------- Hot flushes
-------- Restless sleep
-------- Thirst
-------- Hot hands & feet
-------- Feel hot easily or dislike of hot weather
-------- Panic attacks
-------- Anxiety

PLEASE READ CAREFULLY AND SIGN

To the best of my knowledge the above information is correct and should my medical situation change, I will inform the practitioner. I consent that should I not be able to give 24 hours notice of cancellation, I will incur a late cancellation fee (equivalent to the amount charged for the booked appointment).

Signature____

Date______________________