Heart & Hands Community Acupuncture

851 Cormorant St. Victoria, BC   V8W 1R2
250-590-3185   www.heartandhandscommunity.ca

Patient History Form and Registration

Patient Information	Contact Information
Name ____ Pronouns ______________________________ Address ____ ____ Occupation____ Birth date (yyyy/mm/dd) ______/____/____ BC CareCard # __ __ __ __ __ __ __ __ __ __ __ Physician + ph # _________________________________ **How did you hear about our clinic?** ¦word of mouth ¦online ¦walk-by ¦flyers	Home ph _______________Other ph_________________ Email ____ Emergency contact ____________________________ Relationship ____________ Ph #_______________ ***If patient is under 12 yrs of age*** **Parent/guardian** _________________________________ **Signature** ______________________________________ **Ph #** __________________ **Alt #** __________________ **Witness** __________________________________

Main complaints

Please list your main health complaints/concerns in order of importance to you as well as additional information below.

1. ______________________________

MILD 1---2---3—4—5—6—7—8—9—10 SEVERE
Duration:_____________________________________
Other treatments:______________________________
What makes it **better** ___________________________
What makes it **worse** ___________________________

2. ______________________________

MILD 1---2---3—4—5—6—7—8—9—10 SEVERE
Duration:_____________________________________
Other treatments:______________________________
What makes it **better** ___________________________
What makes it **worse** ___________________________

3. ______________________________

MILD 1---2---3—4—5—6—7—8—9—10 SEVERE
Duration:_____________________________________
Other treatments:______________________________
What makes it **better** ___________________________
What makes it **worse** ___________________________

Health History

*Please indicate by the conditions below with an **S** if you have had the condition and the year it started.*
*If there is a family history indicate with an **F**.*

__ Cancer
*type?*________________
__ Diabetes
__ Heart Disease
__ Pacemaker
__ Osteoporosis
__ Seizure disorder
__ Stroke/TIA
__ Thyroid condition
Hyper / Hypo
__ **Bleeding disorder**
__ Anemia
__ Mononucleosis
__ **Blood borne disease**
__ Mental health/addictions
__ Stroke
__ Asthma/Allergies
*type?*________________
__ Autoimmune disease
*type?*________________

Medications *(include herbs or supplements)*

____
____
____
____
____

Injuries/Surgeries *(note where on body & when, also include dental)*

____
____
____
____
____

How do you sleep? *(trouble falling or staying asleep, dreams, waking often- at specific times, etc.)*
____
____
____

How is your digestion? *(appetite, bowel movements, bloating, nausea, heartburn, etc.)* ______________________
____
____
____

Body temperature

(Not necessarily in degrees, but how you feel relative to other people- needing to wear more layers, overheating easily, etc.)

COLDER 1---2---3—4—5—6—7—8—9—10 WARMER

- Cold hands & feet
- Easily chilled
- Numbness location ________
- Thirst, no desire to drink
- Never thirsty
- Always thirsty
- Hot hands & feet
- Hot flashes time of day? ___________
- Night sweating

Energy level

LOWER 1---2---3—4—5—6—7—8—9—10 HIGHER

- Drop in energy *time of day* _________
- Energy drop after meals
- Needs caffeine/stimulants
- Shortness of breath
- Body weakness/heaviness
- High/low blood pressure
- Bleed or bruise easily
- Difficulty focusing
- Poor memory
- Dizziness
- Heart palpitations

Body Moisture (skin, hair, mouth, bowels)

DRIER 1---2---3—4—5—6—7—8—9—10 OILY

- Dry skin or hair/dandruff
- Dry eyes
- Dry/brittle nails
- Dry nose/mouth/throat
- Edema/swelling
- Itchiness/rashes
- Acne
- Eczema or psoriasis
- Oily skin/hair
- Weight gain/loss
- Dry stools
- Mucus in stools

Emotions *(experienced frequently)*

- Anger
- Irritability
- Anxiety
- Fear
- Sadness/grief
- Depression
- Hyperactivity
- Timid/shy
- Indecision
- Obsessive thoughts

Ear, Nose Throat

- Vision loss
- Sinus congestion
- Hearing loss
- Red eyes
- Sore throat
- Tinnitus
- Itchy eyes
- Cold sores/cankers
- Excess earwax
- Floaters/spots
- Phlegm
- Dental issues
- Night blindness *colour*____________
- Lingering cough

Gender transitioning, hormonal therapies, surgery
additional info, pls list_______________________________
____
____

Menstrual/Hormonal History:

Age of 1st menses ___ Length of cycle (# days) _________
days of bleeding _______
of pregnancies- births ____ premature ____
# of abortions/miscarriages ____ Cesarian Section
Bleeding: heavy light irregular clots
PMS: Yeast infections Digestive changes Breast tenderness Moodiness fatigue
Cramping: before menses 1st day during
Contraception type ______________________________
Poly-Cystic Ovaries Hysterectomy
Fertility treatments _______________________________
____
Currently or potentially pregnant
Menopausal, *symptoms* ___________________________
____
____
____

Welcome to our community. To your health and wellness ☺
The information on this form is accurate to the best of my knowledge:

Signature_______________________________________ Date________________________