HEALTH INFORMATION FORM

Name_____Date of Birth_____

Address_____

_____Postal Code_____

Phone (home)_____(cell)_____

Email_____

Emergency contact_____Phone_____

Are you… Married___In a relationship____Divorced___Widowed___Single____

Current occupation, if any_____

What is your current health concern?

_____

_____

_____

When did this problem start?_____

Is it… Getting worse____Constant____ Comes and goes____Getting better____

Family Medical History:

Illnesses in the family_____

_____

Personal Medical History:

Major illnesses since birth_____

Surgeries_____

Name of your family doctor and/or specialist_____

Are you actively under the care of a health practitioner? Yes / No (please circle)

If yes, who?_____

Known allergies_____

_____

Medications or nutritional supplements you are taking_____

_____

_____

Do you get… fever and/or chills____unusual sweating____unusual odors/ discharges____

Current habits	Coffee	yes / no.	_____ cups daily
	Alcohol	yes / no	_____ glasses daily
	Smoking	yes / no	_____ cigarettes daily
	Marijuana	yes / no	frequency/wk or mth_____
	other drug use_____		

Significant stresses (please list)_____
Describe your sleep pattern (any difficulty falling or staying asleep? Hrs/night?__

_____

Head/Neck:

Describe any pain or difficulties with your head/neck_____

_____
Any problems with your senses? (e.g. Hearing, tasting, smelling, odd tastes)____

_____

Chest:

Cough/phlegm?_____ breathing problems?_____

Heart palpitations or chest pain?_____Blood pressure issues?_____

Gastrointestinal:

How often do you eat?_____Do you have regular meals?_____
How is your appetite?_____Any recent changes?_____
Do you get… bloating____ gas____ bad breath____ burping____ heartburn____
constipation____ diarrhea____abdominal cramping/pain____

Comments on your bowels (e.g. how often, unusual odor/color etc.)_____

_____

Genitourinary:

Problems with your urine/urination_____

Do you have to get up at night to urinate? Yes / no How often?_____

Reproductive:

Do you have any fertility issues?_____

Current type of birth control, if any_____
For women:
Number of pregnancies_____ Number of births_____
Most recent PAP test _____Any abnormalities noted? yes / no
For people who menstruate:
Is your period regular? _____ How many days is your cycle?_____
Do you experience… pain____ clots____ discharge____ emotional changes_____

Musculoskeletal/Neurological:

Describe any aches, pains, or unusual sensations anywhere on your body_____

_____

_____
Have you ever sustained any physical injuries as a result of an accident? If yes, please describe what happened, injuries sustained, treatment received, and

residual limitations_____

_____

_____
Are you engaged in any legal action? Yes / no

Skin:

Please list any problems with your skin (e.g. rashes, eczema, pimples, etc.)_____

_____

Do you have swelling anywhere in your body?_____

Is there anything else you would like to share that is a relevant concern, or is

helpful for me to know?_____

_____

_____

Client Declaration:

I hereby declare that the above information is correct and that I have not withheld any medical information specifically requested.

I understand that acupuncture is not covered under British Columbia Medical Services Plan, and therefore I am responsible to pay for all costs incurred per visit. Payment is made by E-transfer, cash or cheque (payable to Saskia Peck) on the date of service.

I also understand that there is a 24 hour cancellation policy in effect. With any late cancellation or absence of a booked appointment, a $60 fee will automatically be billed to my account. No further treatment will be provided until any such fees are paid.

_____

Client's signature

_____

Date