

The Pacific Wellness Institute
80 Bloor Street West, Suite 1100, Toronto, Ontario

Please complete this form as thoroughly as possible. The information provided is kept confidential according to The Pacific Wellness Institute Privacy Policy. This completed form is required before your session.

Date: _____ Height: _____ Weight: _____

Mr. Mrs. Ms. Dr.

Family name: _____ Given name: _____

Address: _____

_____ Apt. # _____ Postal Code: _____

Telephone: (_____) _____ (H) (_____) _____ (B)

E-mail: _____

Date of Birth (mm/dd/yr): _____ Occupation: _____

How did you hear about us? Please specify: _____

If you are referred, please indicate the name of the person who referred you: _____

Did the person who referred you suggest that you see any particular practitioner at Pacific Wellness?
If so, whom? _____

If you found us through a website, please indicate the site you found first:

www.pacificwellness.ca www.acupuncture-treatment.com other: www. _____

Are you claiming all__ or part __of our fee under insurance? Yes No

Does your insurance company allow direct billing from us? Yes No Don't know

If you are involved in an unsettled car accident case please indicate here _____

Name of your family physician: _____ When was your last check up? _____

Results? _____

Have you ever had any acupuncture treatments before? Yes _____ No _____

If yes, Name of previous acupuncturist: _____

When was your last visit? _____ Briefly describe your experience: _____

Please list your health concerns that you want us to address in order of importance:

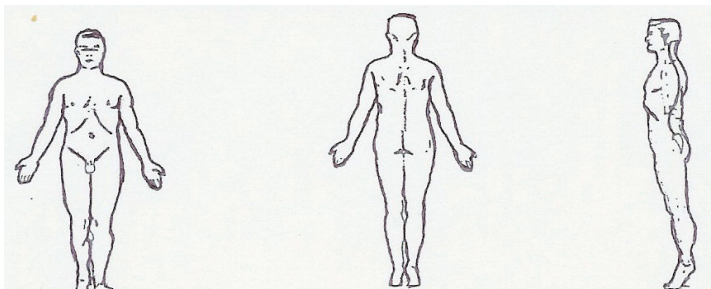
Health concerns: _____ How long have you had this condition? _____

1 _____

2 _____

If any other health practitioners are involved in the care of the condition(s) you indicated, please list their names and specialties:

Please mark the areas of pain, discomfort or any other symptoms on the pictures below:



- x Severe Pain
- ≡ Moderate Pain
- \ \ Stiffness/Tension
- ~ Numbness/Tingling
- I Skin infection/irritation
- P Internal pins/wires
- S Scars (surgery/ injury wounds)

If you are experiencing pain symptoms, please indicate the intensity of pain: _____
(0 being no pain and 10 being the worst pain ever)

Do you notice an increase or decrease in your symptom(s) depending on the:

Time of day? _____ Weather? _____
Time of year? _____ Time of month (according to menstruation cycle)? _____

List all surgery, accidents, and falls:

Date	Details

Please check below, if you have any of the following conditions (past or present). Include details:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Collapsed lung(s) | <input type="checkbox"/> Decreased sensation |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal/Joint disorder | <input type="checkbox"/> Vision/Hearing loss |
| <input type="checkbox"/> Tumor/Cancer | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Internal pins/wires |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Seizures | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Night sweating | <input type="checkbox"/> Other: _____ |

Details: _____

Please indicate if you had (or currently have) any of the following:

- Hepatitis HIV (AIDS) Skin diseases (or infection) Herpes
- STD Other infectious disease _____

Are you experiencing ___ anxiety or ___ depression or suffering from any mental/emotional disorders?

Have you ever experienced any of the following?

- Dizziness or lightheadedness when standing quickly from sitting position
- Tingling, numbness, or prickling sensation in hands and feet
- Fainting, dizziness or nausea during routine doctor's visit or blood donation
- Acute illness or condition that required emergency visits
- Condition that required hospitalization

Details: _____

Please indicate if you have experienced any of the following in the last 12 months:

- Reoccurring persistent infection in ___bladder, ___skin, ___gums, or ___genitals
- Unexplained weight loss of 10 pounds or more Bruise easily Decreased energy
- Changes in bowel function (constipation, diarrhea, black stool, difficulty controlling etc.): _____
- Changes in urinary function (change of frequency, incontinence, dark urine, blood in urine, etc.): _____

For women only

Are you pregnant? Yes No Maybe If yes, how many months? _____

Typical length of your cycle: _____ days First day of your last period: _____

Age at which menses began: _____ How many days do you normally bleed? _____

Past pregnancies (how many, when): _____

Check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Scanty blood flow | <input type="checkbox"/> Heavy blood flow | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Clear vaginal discharge | <input type="checkbox"/> White vaginal discharge | <input type="checkbox"/> Excessive body or facial hair |
| <input type="checkbox"/> Cheesy white discharge | <input type="checkbox"/> Greenish or yellow discharge | <input type="checkbox"/> Acne/Skin problems |
| <input type="checkbox"/> Irregular menstrual cycle | <input type="checkbox"/> Brown discharge | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Brittle nails/hair | <input type="checkbox"/> Clotted blood in menses | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Menstrual pain, cramps | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Absence of periods |
| <input type="checkbox"/> Pre-menstrual symptoms (PMS) | <input type="checkbox"/> Discharge from nipples | <input type="checkbox"/> Other: _____ |

If you are taking any medication, vitamins, herbs, or nutritional supplements please list below:

Drug/Supplement name:	Dosage:	For what condition?	For how long?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Your diet for the last 3 days:

	Day 1		Day 2		Day 3	
	Food	Beverages	Food	Beverages	Food	Beverages
Before breakfast						
Breakfast						
Between						
Lunch						
Between						
Dinner						
After dinner						
Bowel movements	Time(s)		Time(s)		Time(s)	
Comments if any: bloating, indigestion, heart burn, hives, fatigue, insomnia, etc.						