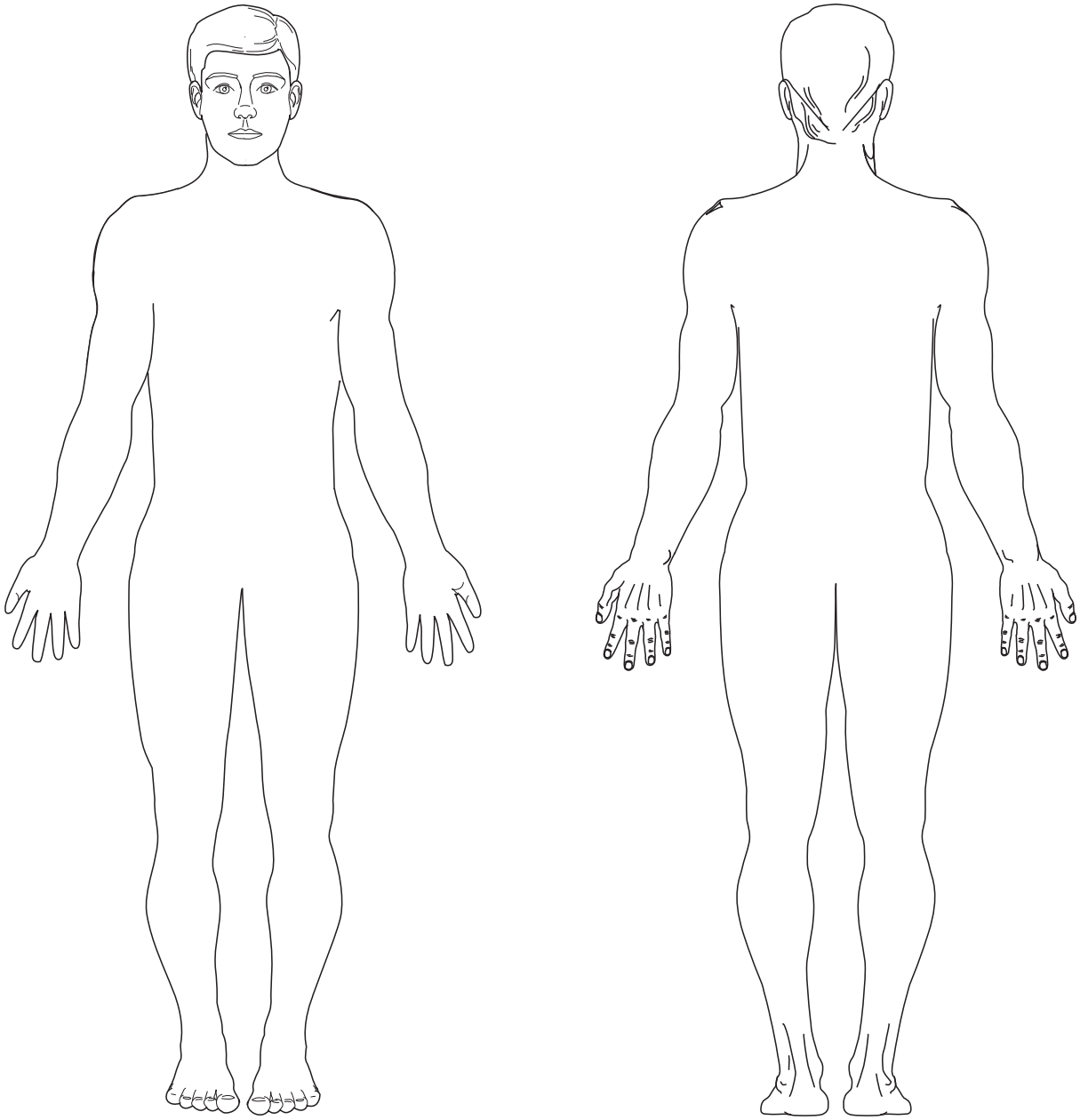
Please circle or use crosshatching to indicate
areas of pain or discomfort.

Please draw or indicate with a star, *,
all scars or fractures,
no matter how old.



Shuswap Acupuncture Clinic and Chinese Medicine Centre
Patient Health History

Name: _____ Date: M_____/D_____/Y_____
FIRST MIDDLE LAST

Address: _____ City: _____ Postal Code: _____

Date of Birth: M_____/D_____/Y_____ Age: _____ E-mail address: _____

Home #:_____Work #:_____Cell #: _____

How would you like to receive your appointment reminders? ❑ Email ❑ Phone

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Please write clearly and indicate areas of confusion with a question mark. Thank you!

1. Name of primary medical care provider (MD, ND etc)_____

2. Please identify the health concerns that have brought you to Shuswap Acupuncture in order of importance below:

Condition	**Past Treatment**
a. _____	_____
b. _____	_____
c. _____	_____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

_____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

5. Do you have any reason to believe you may be pregnant? Y N

If so, estimated month: _____

6. Do you have any infectious diseases? Y N If yes, please identify: _____

7. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

8. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

9. **Family History:**

Has anyone in your immediate family (blood relation) had any of the following conditions? Please circle the condition and say how you are related to the person.

Cancer:	Diabetes:	Heart Disease:	High Blood Pressure:
Stroke:	Asthma	Hay fever/Hives:	Kidney Disease:

10. **Hospitalizations and Surgeries (include root canals or other dental surgery):**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

11. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

12. **Emotional** (please ***circle*** for now and ***underline*** for past):

Mood Swings Nervousness Mental Tension Depression

13. **Energy and Immunity** (please ***circle*** for now and ***underline*** for past):

Fatigue Slow Wound Healing Recurrent Infections Frequent colds / flu

14. **Head, Eye, Ear, Nose, and Throat** (please ***circle*** for now and ***underline*** for past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Visual Floaters/Spots	TMJ/Jaw Problems	Hay Fever

15. **Respiratory** (please ***circle*** for now and ***underline*** for past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Bronchitis	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

16. **Cardiovascular** (please ***circle*** for now and ***underline*** for past):

Heart Disease Chest Pain Swelling of Ankles High or Low Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

17. **Gastrointestinal** (please ***circle*** for now and ***underline*** for past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

18. **Genitourinary Tract** (please ***circle*** for now and ***underline*** for past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Constipation

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

19. **Female Reproductive/Breasts** (please ***circle*** for now and ***underline*** for past):

Irregular Cycles Breast Lumps/Tenderness Endometriosis Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods Fibroids/Cysts

20. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____ 9. Abnormal pap? _____

Date of last menstrual cycle: _____

21. **Male Reproductive** (please ***circle*** for now and ***underline*** for past):

Sexual Difficulties/ED Prostate Problems Testicular Pain/Swelling Penile Discharge

22. **Musculoskeletal** (please ***circle*** for now and ***underline*** for past):

Neck/Shoulder Pain Muscle Spasms / Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

23. **Neurologic** (please ***circle*** for now and ***underline*** for past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy Concussion

24. **Endocrine** (please ***circle*** for now and ***underline*** for past):

Hypothyroid Hyperthyroid Hypoglycemia Diabetes I / or II Night Sweats Feeling Hot / or Cold

25. **Other** (please ***circle*** for now and ***underline*** for past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Insomnia

26. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. How many hours per night do you sleep? _____ Do you wake rested? Y N

d. Occupation: _____

e. Nicotine/Alcohol/Caffeine Use: _____

f. How many glasses of water do you drink a day? _____

g. Have you experienced any major traumas? Y N Explain: _____

_____

How did you hear about us? _____

Thank you!

SHUSWAP ACUPUNCTURE CLINIC and LASER THERAPY

2-140 Harbourfront Drive NE, Salmon Arm, BC V1E 2T3
Phone 250.833.5899 ~ Fax 250.833.4977

CONSENT AND RELEASE FORM

I, the undersigned, do hereby authorize: (***Select applicable practitioner/s)***

- ☐ Donna Rasplica, BC Registered Doctor of Traditional Chinese Medicine (License #FD03065)
- ☐ Lynne Ozone, BC Registered Acupuncturist (License #FA03113)
- ☐ Chris Davies, BC Registered Acupuncturist (License #FA04383)
- ☐ Gillian Marsollier, BC Registered Acupuncturist (License #FA01788)

to perform any of the following:

- **Acupuncture:** insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the body.
- **Electroacupuncture:** using small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** applying heat generated by an infrared lamp over a specific area of the body.
- **Moxa:** indirect or direct burning of an herbal compound on acupoints using stick or cone moxa.
- **Cupping:** cups made of glass or other materials are placed on the skin with a vacuum created by heat or suction device.
- **Tui Na:** Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** herbal formulas applied topically to the skin.
- **Nutritional Advice:** includes diet and herbal recommendations.
- **Laser:** focused light to stimulate acupuncture points.

I understand the potential benefits and risks of these procedures include:

- **Potential Benefits** (including but not limited to): drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.
- Although rare, minimal, and short term, **Potential Risks** include but are not limited to: discomfort, bruising, bleeding, possible temporary aggravation of symptoms existing prior to the acupuncture treatment.
- Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the above named practitioners regarding cure or improvement of my condition. In order for the above named practitioners to perform these procedures, I release them from any liability that may occur in connection with my treatment. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

_____ _____

Signature of patient (or guardian if under 18) **Date**