ACACIA Integrative Health Clinic

***Health History Form* (ACUPUNCTURE)**

General Information:

Name_____ Birth-date _____ Date_____ MSP #_____

Blood Type_____ Address_____ City _____ Prov/State_____

Postal Code_____ Phone (home)_____ Phone (work) _____

best time to call _____ Can we leave messages for you here? Y ☐ N ☐ Email _____

Occupation_____ full-time ☐ part-time ☐

Emergency contact _____relation? _____Phone_____

How did you hear about us?_____

Please list below all other health professionals you are currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, Chiropractor, etc...)_____
_____
_____

Current Health Concerns:

What is your chief complaint?_____
_____
_____

Please describe the history of your condition._____
_____
_____

In order of importance, list any other health concerns that are troubling you:

1) _____Since when?_____

2) _____Since when?_____

3) _____Since when?_____

List all medications, supplements, herbs, and homeopathic medicines you are currently taking. Include dosage and results: _____
_____
_____

Your Health History

Your general state of health is: excellent ☐ good ☐ average ☐ fair ☐ poor ☐

Current weight_____ Height _____ Weight 1 year ago _____Max adult weight _____ Min adult weight _____
Please list the three most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (If so place a star next to the event)

1)_____ Date_____

2)_____ Date_____

3)_____ Date_____

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How often do you get colds and flus? _____
Do you have any allergies to any drugs, herbs, foods, animals or other? (yes / no) Please list:

_____

_____

Are you currently working with a professional counselor, psychologist, social worker, pastor, rabbi, psychiatrist, or other therapist?
YES ☐ NO ☐ Have you in the past? YES ☐ NO ☐ If yes, when?_____

Childhood Diseases (please circle if you have had the following):

measles	mumps	chickenpox	whooping cough	polio	diphtheria	roseola
rheumatic fever	scarlet fever	small pox	typhoid fever	tuberculosis	rubella	mono

Previous surgeries and hospitalizations not mentioned above (include dates):

_____

_____

Which of the following have you had and please **indicate when.**

Chronic infections_____	Hypoglycemia_____	Asthma_____	Heart attack_____
Pneumonia_____	Diabetes_____	Gonorrhea_____	Heart Failure_____
Tonsillitis_____	Cancer_____	Syphilis_____	Anemia_____
Ear Infections_____	Eczema_____	Venereal warts_____	Obesity_____
Heart disease_____	Epilepsy_____	Canker sores_____	Hyperthyroidism_____
Oral herpes_____	Genital herpes_____	Hypertension_____	Hypothyroidism_____
Allergies_____	HIV _____	Hepatitis A B or C_____	

Your Lifestyle

Are you (circle): married separated divorced widowed single in a supportive relationship in a same sex relationship, or other_____

What do you enjoy most in your life? _____

What are your main interests and hobbies? _____

What do you worry about most in your life? _____

How often do you exercise per week? _____ What kind and for how long? _____

Do you have a religious or spiritual practice and what is it? _____

Do you have dietary restrictions, religious or ethical? _____

Do you enjoy your work? YES ☐ NO ☐ Do you take vacations? YES ☐ NO ☐

Do you currently use any of the following (indicate how often, how much and for how long):

Alcohol_____ Tobacco_____ Coffee _____

Soft drinks_____ Black tea _____ Marijuana _____

Laxatives _____ Other recreational drugs _____ Pain medication _ _____

Other intoxicants_____

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Female Reproduction

Age of first period _____ Age at menopause _____ Length of cycles_____

Length of bleeds_____ Are they: heavy ☐ medium ☐ light ☐ clotted ☐ dark ☐ light color ☐

Do you have spotting or bleeding between periods and since when?_____

Do you have PMS? ____(circle all that apply) bloating, breast tenderness, irritability, depression, headaches, mood swings, food cravings

Number of pregnancies _____ Number of abortions _____ Number of live births_____ Number of miscarriages _____

Have you had difficulty conceiving? (Please describe) _____

Date and results of last PAP smear _____ Mammogram _____Self breast exam_____

Have you ever had an abnormal pap/mammogram? YES ☐ NO ☐ If yes, when? _____

Are you sexually active? YES ☐ NO ☐ If you use birth control, what kind? _____

Have you ever been or are now physically or sexually abused? _____

Male Reproduction

Any problems with impotency? YES ☐ NO ☐ Any sores on your penis? YES ☐ NO ☐ Any discharge? YES ☐ NO ☐

Any problems urinating? YES ☐ NO ☐ Any known prostate problems? (if so describe)_____

Date of last prostate examination_____ Date of last self testicular examination _____

Are you sexually active? YES ☐ NO ☐ If you use birth control, what kind?_____

Have you ever been or are now physically or sexually abused? _____

Your Work and Home Environment

How long have you lived at your present address?_____ Where have you lived previously?_____

Describe your current living arrangements._____

Describe the emotional environment at home._____

Is your home damp or moldy? YES ☐ NO ☐ How is your home heated?_____

Can you open windows where you work? YES ☐ NO ☐ Is their air filtration systems at work? YES ☐ NO ☐

Does your work expose you to toxic chemicals and fumes? YES ☐ NO ☐ Describe_____

Do any of your hobbies expose you to toxic chemicals? YES ☐ NO ☐ Are you exposed to second hand smoke? YES ☐ NO ☐

Thank you for taking the time to fill out this form.

Please return this form to your Acupuncturist:

Victoria Spaurel R.Ac
101-391 Tyee Road, Victoria B.C. V9A 0A9

Confidentiality and Informed consent to Treatment
For Acupuncture Patients

Traditional Chinese Medicine has been used for over 2,500 years and is a very safe, natural and effective way of preventing disease as well as treating acute and chronic health issues. Acupuncturists observe the whole person, body, mind and spirit to assess, diagnose and treat each individual patient.

A Registered Acupuncturist has in-depth training in TCM medical theory and diagnosis, acupuncture point location and needling techniques, and will provide you with the best benefits of acupuncture. Your Acupuncturist will offer you an effective treatment plan that may include, diet and physical activity, acupuncture, moxibustion, cupping, patent herbal remedies, relaxation techniques, and preventative practices.

I understand that I must inform my Acupuncturist immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant or suspect I may be pregnant.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the Acupuncturist at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment.

I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.

I understand that the results are not guaranteed. I do not expect the Acupuncturist will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this Acupuncturist. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) _____

Name of guardian if patient is a child: _____

Signature of Patient (or Guardian): _____

Date: _____

Optional Consent (please initial box)

☐ I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

Acupuncturist Signature: _____

Date: _____