



Chiropractic • Naturopathy • Massage Therapy • Acupuncture

3885 Duke of York Blvd., Suite C211, Mississauga, ON L5B0E4 T: (905)276-6800 F: (905)276-6802 www.NaturaWellnessClinic.com

DATE OF FIRST VISIT: _____

ACUPUNCTURE - NEW PATIENT INFORMATION FORM

NAME: _____ D.O.B. (DD-MM-YY): ____ - ____ - ____ PLACE OF BIRTH: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

TEL: (Home) _____ (Work) _____ (Cell) _____

MAY WE CONTACT YOU BY PHONE/E-MAIL FOR UPDATES, EDUCATIONAL NEWS OR CLINIC PROMOTIONS? Y / N

E-MAIL ADDRESS: _____

Reason for visit today:

Are you on medication? (If so, for what condition) (Including vitamins and herbs)

Surgery (date and details):

Any major traumas (auto, fall, etc.)?

Significant Illnesses

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> History of fainting |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Allergies: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Habits and frequency:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cigarettes: _____ | <input type="checkbox"/> Caffeine: _____ | <input type="checkbox"/> Alcohol: _____ |
| <input type="checkbox"/> Drugs: _____ | <input type="checkbox"/> Salt: _____ | <input type="checkbox"/> Sugar: _____ |
| <input type="checkbox"/> Cravings: _____ | <input type="checkbox"/> Other: _____ | |

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Please check of any of these symptoms apply to you:

Skin and Hair

- Rashes
- Pimples
- Ulcerations
- Eczema
- Hives
- Dandruff
- Itching
- Loss of hair
- Easy bruising
- Excessive sweating
- Night sweating
- No sweating
- Dry skin
- Recent moles
- Other: _____

Head and Neck

- Headache
- Migraines
- Dizziness
- Fainting
- Concussions

- Swollen glands
- Stiff neck
- Other: _____

Ears

- Ringing
- Earache
- Poor hearing
- Vertigo
- Other: _____

Eyes

- Glasses/contacts
- Blurry vision
- Eye strain
- Eye pain
- Poor night vision
- Cataracts
- Spots/floaters
- Other: _____
-

Nose, Throat, Mouth

- Sinus problems
- Nose bleeds
- Dry nose
- Difficulty swallowing
- Mouth/ tongue ulcers
- Frequent sore throat
- Excessive thirst
- Dry mouth
- Jaw clicks
- Grinding teeth
- TMJ
- Facial pain
- Other: _____

Respiratory

- Chronic cough
- Coughing blood
- Production of phlegm
- Asthma
- Wheezing
- Shortness of breath
- Tight chest

- Difficulty breathing
- Difficulty breathing lying down
- Other: _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain/ tightness
- Palpitations

- Irregular heartbeat
- Cold hands/feet/poor circulation
- Swollen hands/feet
- Blood clots
- Anemia
- Sciatica
- Bruise easily _____
- Tremors
- Chills/fever

- Other: _____

Gastrointestinal

- Nausea
- Stomach pain
- Indigestion
- Vomiting
- Diarrhea
- Constipation
- Gas
- Hiccups
- Bad breath
- Acid regurgitation
- Bloating
- Laxative use
- Mucous in stool
- Blood in stool
- Rectal pain
- Hemorrhoids
- Poor appetite
- Excessive hunger
- Weight loss/gain
- Peculiar tastes smells bothersome
- Other: _____

Urinary

- Pain on urination
- Frequent urination

- Uncontrolled bladder
- Incomplete urination
- Bedwetting
- Wake to urinate
- Cloudy urination
- Blood in urine

- Kidney stones
- Other: _____

Genito

- Increased/decreased libido
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitals
- Other: _____

Obstetrics and Gynecology

Number of pregnancies: _____

Number of births: _____

Number of miscarriages: _____

Abortions: _____

Age at first menses: _____

Length of cycle: _____

Of days bleeding: _____

Dull red, dark red, purple, brown in color? (Circle)

Clots

Irregular period

Light/heavy

PMS- before, during, after

Vaginal discharge

Hormone imbalance

Breast lumps

Menstrual cramps

Other menstrual related pain: _____

Changes in body/psyche prior to or during menstruation/ PMS symptoms: _____

Sleep

Poor sleep

Insomnia

Unrested upon waking

Dreaming

Dream disturbed

Night sweats

Other: _____

Musculoskeletal

Joint pain/disorder

Localized weakness

Limited range of motion

Neck pain

Upper back pain

Shoulder pain

Lower back pain

Hip pain

Knee pain

Foot/ankle pain

Wrist/hand pain

Other: _____

Neuropsychological

Irritability

Depression

Anxiety

Mood swings

Poor short term memory

Poor long term memory

Bad temper

Sudden energy drop (time of day _____)

Stressed out

Poor coordination

Poor balance

Fatigue

Areas of numbness

Seizures

Tremors

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Other neurological or psychological problems _____

Authorization for Treatment

I understand the nature of the treatments provided by Ansen Liuu and agree to work with her to attain my optimum health. I will provide as much background information as necessary and I realize that this information is confidential and is strictly used for the benefit of my treatment.

Signature: _____

Date: _____