COUNTRY HILLS CHIROPRACTIC & WELLNESS
Phone: (403)-547-7877

Confidential Patient Health History

Name:_____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Occupation: _____

Marital Status: _____ Age: _____

Physician: _____ Chiropractor: _____

Emergency Contact: _____

Who referred you? _____

What is your chief complaint or reason(s) for this visit?

_____

_____

_____

When did you first notice symptoms?

_____

What improves the condition?

_____

What worsens the condition?

_____

What treatment have you tried?

_____

Have you received Acupuncture treatments before? YES / NO

Are you willing to take Chinese Herbs if so prescribed by your practitioner? YES / NO

List any Medications or Supplements you are currently taking:

_____

_____

_____

List any medication, food, or environmental substances that you are allergic to, and the reaction you have:

_____

_____

_____

Do you consume caffeine, alcohol, tobacco, or recreational drugs? YES / NO
If YES, how often and how much of each?

_____

_____

Do you exercise regularly? YES / NO

If YES, describe the type of activity you do, and how often you do it:

_____

SYMPTOMS: Check symptoms you currently have, or have had in the past year.

	GENERAL		NOSE, THROAT & MOUTH con't		DIGESTIVE SYSTEM
	Fatigue		Difficulty in Swallowing		Nausea
	Insomnia		Change in Sense of Taste		Vomiting Food
	Disturbed Sleep		Tooth or Gum Pain		Vomiting Blood
	Frequent Dreams		Bleeding Gum		Diarrhea
	Excessive Sleep		Mouth or Tongue Ulcers		Constipation
	Dislike Cold		Other:		Loose Stools
	Dislike Heat				Bloody / Black Stools
	Weight Gain		**MUSCLES & JOINTS**		Stomach Pain
	Weight Loss		*Pain, Weakness, or Numbness in:*		Abdominal Pain
	Fever		Neck / Shoulder / Arm / Hand		Poor Appetite
	Chills		Hip / Leg / Feet		Excessive Hunger
	Alternating Chills & Fever		Sore Low Back and Knees		Abdominal Bloating / Gas
	Night Sweats		Muscle Cramps		Belching
	Unusual Daytime Sweats		Body Pain		Indigestion
	Unusually Thirsty		Heavy Limbs		Acid Reflux
	Seldom Thirsty		Swollen Joints		Haemorrhoids
	Edema or Swelling		Hot Joints		
	Other:				**URINARY / GENITAL**
			NERVOUS SYSTEM		Painful Urination
	SKIN		Fainting		Difficult Urination
	Rashes		Paralysis		Frequent Daytime Urination
	Hives		Tremors		Frequent Nighttime Urination
	Dry Skin		Poor Balance		Incontinence
	Acne		Seizures		Cloudy Urine
	Easily Bruised		Other:		Bloody Urine
	Changes in Lumps or Moles				Genital Pain or Itching
	Unusual Bleeding		**HEART, LUNGS & CHEST**		Genital Discharge or Lesions
	Eczema		Palpitations		Painful Intercourse
	Other:		Chest Pain		Low Sexual Drive
			Tightness		Excessive Sexual Drive
	HEAD & NECK		Rapid Heart Beat		Other:
	Headaches (note type & location of pain)		Swelling of the Ankles		
	Dizziness		Cough		**MALE**
	Jaw Pain		Dry Cough		Impotence
	Other:		Coughing Up Phlegm		Weak Urinary Stream
			Coughing Up Blood		Prostate Hypertrophy
	EYES & EARS		Shortness of Breath		Seminal Emissions
	Failing Vision		Asthma / Wheezing		
	Blurred Vision		Frequent Colds		**FEMALE**
	Visual Spots		Pain in Rib Cage		Irregular Periods
	Night Blindness		Other:		Painful Periods
	Eye Pain/Swelling				Bleeding Between Periods
	Ringing in the Ears		**MENTAL / EMOTIONAL**		Passing Clots
	Decreased Hearing		Difficulty Concentrating		Scanty Periods
	Ear Pain		Poor Memory		Early Periods
	Ear Discharge		Worry		No Periods
	Other:		Anxiety		PMS
			Depression		Menopausal Symptoms
	NOSE, THROAT & MOUTH		Irritability		Abnormal Pap Smear
	Nose Bleeds		Frustration or Anger		Breast Lump
	Nasal Discharge/Infection		Fearfulness		Breast Pain or Discharge
	Frequent Sneezing		Stress		Vaginal Discharge
	Change in Sense of Smell		Other:		Other:
	Sore Throat				
	Hoarseness				

CONDITIONS: Please check conditions you currently have, or have had in the past:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fatigue Problem
- ☐ Fibromyalgia
- ☐ Gallbladder Problem
- ☐ German Measles
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Intestinal Disorder
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Measles
- ☐ Menstrual Disorder
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Stomach Disorder
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infection
- ☐ Vaginal Infection
- ☐ Venereal Disease
- ☐ Other:
- ☐ Other:
- ☐ Other:

FAMILY HISTORY: Please check if your blood relations have had any of the following:

- ☐ Arthritis / Gout
- ☐ Asthma
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other:
- ☐ Other:

HOSPITALIZATIONS: Please note if you have ever been hospitalized and why:

_____

_____

_____

WOMEN ONLY: Please answer the following questions if applicable to you.

Pregnancy and Birthing history: Please note the number of pregnancies you have had, the number of deliveries you have had, and any relevant information:

_____

_____

Date of last menstrual period?_____

Age of first menstrual period?_____

Date of onset of menopause?_____

Date of last Pap Smear?_____

Are you pregnant?_____ Are you trying to become pregnant?_____

Are you currently using birth control? What type? _____

Patient Signature:_____

Date:_____

Acupuncture
Consent to Treatment Form

By signing below, I do hereby consent to be treated with acupuncture and/or Chinese herbs by Chantel Moen R.Ac., and Alexandria Besaw R.Ac.
I understand that section 8(1) of Alberta's Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless

(a) that person has already consulted with a physician, or in the case of a dental pathology, a dentist, about the condition for which care and treatment from the acupuncturist is being sought;
(b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition; and
(c) the acupuncturist has completed a patient consultation form

Have you consulted with a physician or dentist (as appropriate) about the condition for which the acupuncture treatment is now being sought? YES / NO

Acupuncture / Acupressure / Cupping: I understand that acupuncture/acupressure/cupping is performed by the insertion of needles through the skin or by pressure/suction at certain points on the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain, or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Extremely rare but serious problems have been reported in literature such as joint infection, nerve damage, pneumothorax, and needle breakage. I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that Chinese Herbs may be recommended to me in an attempt to treat bodily dysfunction and diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. Should I experience any problems, which I associate with these substances I should suspend taking them and call the acupuncturist as soon as possible.

Electro Acupuncture: I understand that I may be asked to have electro-acupuncture administration. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to, electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature:_____ **Date:** _____

Printed Name: _____ **DOB:** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone: _____