

Acupuncture

Confidential Health History Form



12 Irwin Ave Suite 200-201, Toronto, ON M4Y 1K9

The information on this form is confidential and will be used to assist your therapist in determining your treatment plan.

Name: _____ Home #: _____

Address: _____ Cell #: _____

City/Province: _____ Work #: _____

Postal Code: _____ Email: _____

Height: _____ Weight: _____

YES! it is okay to send periodic e-mails

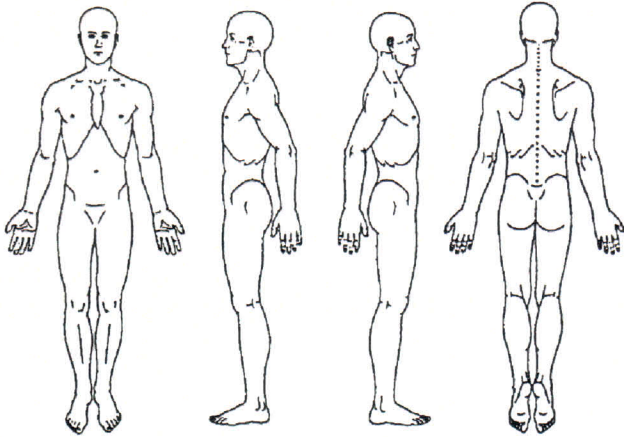
Occupation: _____

Date of Birth ____/____/____
DD/MM/YY

Who can we thank for this referral? _____

Do you have benefits? YES! No What brings you in for acupuncture today _____

Indicate where you feel you pain and or check areas to the right



● - muscle pain ✓ - numbness/tingling
+ - joint pain X - general pain

What is your chief complaint? _____

How long have you had it? _____

When is the pain worse/better? _____

Location of Discomfort:

- Head _____
- Hands _____
- Feet _____
- Neck _____
- Shoulders _____
- Upper back _____
- Mid back _____
- Low back _____
- Arms _____
- Wrists _____
- Legs _____
- Knees _____
- Other: _____

Primary Care Physician: _____

Medications / Supplements

Reason for Taking

Address & Phone: _____

Exercise / Physical Activity: _____

Frequency: _____
