Thornhill Naturopathic HEALTH CLINIC

12A Centre Street
Thornhill, Ontario
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www.thornhillnaturopathic.ca

Tel: 905-707-2001
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Acupuncture Initial Assessment Form

Take a few moments to fill out this questionnaire carefully. All answers will be held strictly confidential. If you have any questions, please ask us**.** Thank you.

Patient information

First Name: _______________________________ Last Name: ________________________________ Sex: M / F Age: _____

Address:____ City: _________________ Postal Code: ____________

Home Phone: ( ) ____________________________ Work Phone: ( ) ______________________________________

Email: _______________________________________ Date of Birth: ______________________ Occupation: _______________

Family Physician: ____ Phone No.: ( ) ___________________________

Address: ____ City: _________________ Postal Code: ______________________

How did you find us? Referred by: _____________________________ Media Ad Street signs Other _________________

Current Condition

Chief Complaint: ____

____

How long have you had this condition? ____

What seems to be the initial cause? ____

What seems to improve this condition? ____

What seems to aggravate this condition? ____

Do you have any internal pins, wires, special equipment, artificial joints (other)? (Example: pace maker, hearing aid): **Y / N**

____

Are you, or are you possibly pregnant? **Y / N** How many weeks? ____

Last appointment with Doctor: ____

What medications, prescribed or otherwise are you currently taking? ____

____

Have you had the experience of acupuncture before? **Y / N**

Date: ________________ Name of Acupuncturist:____

Please list any major injuries, traumas, surgeries, accidents or falls, childhood illness: ____________________________

____

____

Have you been diagnosed with, or have you experienced any of the following? Please indicate with an X below:

Circulatory/ Respiratory System: Chronic Congestive Heart Failure: __ Heart Disease: __ High Blood Pressure: __ Low Blood Pressure: __Other Heart Condition: ________________

Varicose Veins: __ Phlebitis: __ Deep Vein Thrombosis: __ Easily Bruise or Bleed? __Reynaud's Disease: __

Circulation :(e.g. Cold hands and feet): ______________Berger's Disease: __ Chronic Cough: __ Bronchitis: __

Asthma/wheezing: __ Emphysema: __ Shortness of Breath: __

Allergies____

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Skin: Sensitivities to oils/ lotions: __ Other Allergies/ Hypersensitivities: _______________ Irritated Skin Conditions (Example: Eczema/ Psoriasis):_______________ Contagious Conditions: ___ ______________________Frostbite__ Lack of Sensation or Feeling ___________________ Change in hair or skin texture? __ Dry Skin? __ Oily Skin?__ Loss of hair?__ Acne (Location): __________________ Other: ____

General: Cancer/tumors: __(type) ____________ Kidney Disorder:__ Liver Disorder:__ *Infectious Conditions (Example HIV, Hepatitis):__ STI (Sexually transmitted infection):__ (type):* _________________ Loss of vision or hearing:__

Multiple Sclerosis:__ Parkinson's:__ Sciatica: __ Carpal tunnel syndrome:__ *Epilepsy:* __ Stroke(Date):____________

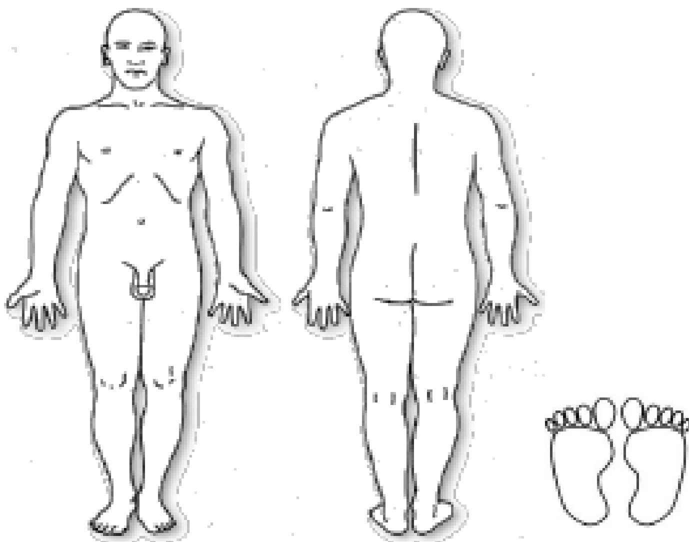
Ringing in Ears:__ Sinus problems: __ Depression:__ Confusion:__ Rapid Weight Loss:__ Anemia:__ Nausea/Vomiting:__

Constipation:__ Diarrhea: __ Diabetes: __ Type__ Alcoholism:__ Tuberculosis:__ Polio:__ Lupus:__ Rheumatic Fever:__ Meningitis:__ whiplash: __

Dizziness* Y / N *Blood Pressure:* _____________*mmHg* *Other: _______________

Joints: Numbness in Limbs: _ Lower Back Pain: __ Difficulty Walking: ___Scoliosis: __ Osteoporosis? ____ Weakness?: ______________ Swelling in Limbs: Joint Instability: __________ Restless Legs:	**Headaches/ *Migraines***: __ What triggers it? (TMJ) ___ Do wear a mouth guard? __

Please Circle current symptomatic areas in the diagram below:



Are you currently experiencing any pain? Y / N
(Low-tolerable) 1 2 3 4 5 6 7 8 9 10 (High- intolerable)
How often do you experience this pain? _____________
Are there any other associated symptoms?
____

How would you describe the pain? Dull; Ache; Sharp; Stabbing; Pricking; Burning; Heavy; Wandering; Fixed; radiating (travels), other: _________________________

What improves the pain? Heat; Cold; Pressure; Rest; Other: ____

What aggravates the pain? Weather Changes; Stress; Menses; Other: _______________________________ _

Does the pain affect daily activities? ____
Does the pain wake you at night? _____

Head and Body:

- ☐ Headaches
- ☐ Migraines
- ☐ Body aches
- ☐ Joint pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Low back pain
- ☐ Muscle pains
- ☐ Weak limbs __________________________________
- ☐ Numbness __________________________________
- ☐ Heaviness __________________________________
- ☐ Stiffness ___________________________________

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Cold and Heat:

☐ Tidal Fever ☐ Cold back ☐Clammy_______________
☐ Cold ☐ Chills ☐ hands/feet_______________
☐ Cold hands/feet ☐ Heat ☐ Fever_______________

Sweating:

☐ Spontaneous ☐ No sweating ☐Local sweats_______________
☐ With exertion ☐ Hot flashes ☐Night sweats _______________

Energy: 1 2 3 4 5 6 7 8 9 10

(1 = Minimal energy, 10 = Maximal energy)

☐ Fatigue ☐ Dizziness ☐Dyspnea / SOB_______________
☐ Fatigues easily ☐ Excess ☐Fainting_______________
☐ Sudden energy drop ☐ Drowsy ☐Heavy feeling_______________

Sleep: ______ Hrs/night

☐ Sound, restful ☐ Heavy sleep ☐ Not restful _______________
☐ Insomnia ☐ Dream disturbed ☐ Grinds teeth _______________

Urine:

☐ Normal ☐ Nocturia ☐ Clear _______________
☐ Polyuria ☐ Infrequent ☐ Dark _______________
☐ Urgency ☐ Dysuria ☐ Excess_______________
☐ Incontinence ☐ Hematuria ☐ Scanty_______________

Stool:

☐ Regular ☐ Loose/watery ☐ Dry, hard _______________
☐ Diarrhea ☐ Foul smell ☐ Burning_______________
☐ Constipation ☐ Gas ☐ Explosive_______________

Thirst:

☐ Thirsty with desire to drink ☐ Likes hot drinks ☐ Dry mouth_______________
☐ Likes cold drinks ☐ Thirsty with no desire to drink ☐ Bitter taste in mouth_______________
☐ Metal taste in mouth_______________

Appetite: 0 1 2 3 4 5 (0 = No appetite, 5 = Heavy appetite)

☐ Cravings ☐ Vomiting ☐ Heartburn_______________
☐ Abdominal pain ☐ Gas ☐ Bad Breath _______________
☐ Nausea ☐ Bloating ☐ Food Preferences _______________

Emotions:

☐ Calm/relaxed ☐ Angry ☐ Grief _______________
☐ Depressive ☐ Irritable ☐ Overthinking_______________
☐ Anxious ☐ Stressed ☐ Fearful_______________

Lifestyle and Body Type:

☐ Smoking ☐ Irregular hours ☐ Alcohol
☐ Weight gain / loss ☐ Shift work ☐ Caffeine
☐ Thin / Heavy ☐ Regular Exercise ☐ Occupational stress factors: _______________

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Eyes:

☐ Blurry vision ☐Eye pain ☐ Burning ____________________________________
☐ Spots in front of eyes ☐ Eyestrain ☐ Red____
☐ Poor vision ☐ Dry eyes ☐Yellow ______________________________________

Ears:

☐ Poor Hearing ☐ Tinnitus ☐Earaches_____________________________________

Skin and Hair:

☐ Rashes ☐ Ulcerations ☐ Dandruff____________________________________
☐ Itching ☐ Eczema ☐ Hair loss____________________________________
☐ Dry skin ☐ Hives ☐ Changes in skin/hair___________________________

Gynecology:

☐ Regular ☐ Clots ☐ Discharge: __________________________________
☐ Irregular ☐ Heavy / Light flow ☐ PMS _______________________________________
☐ Amenorrhea ☐ Pale / Dark colour ☐ Pain _______________________________________

Age at first period: _______________ Age at menopause: ______________ Number of Pregnancies: ________________________

Time between cycles: ____________ Duration of bleeding: _____________ First day of last period: ________________________

Oral contraceptive use: ___________ Type: _________________________ For how long: ________________________________

Other Health Concerns:

____
____
____
____