WHAT'S GOOD

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Traditional Chinese Medicine & Acupuncture
Patient Health Profile *(Private & Confidential)*

First Name | Last Name | Date

Home Address (House number, Unit, Street, City, Postal Code)

Home Phone | Work/Cell Phone | *Email Address

Best time & place to contact you

(MM/DD/YY) Date of Birth | Age | If you are under the age of 18, what are your Parent's first and last names?

Gender ☐ M ☐ F ☐ T

Marital Status ☐ Single ☐ Committed Relationship ☐ Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

Spouse/Partner's Name

Do you have children? ☐ Yes ☐ No

If so, what are your children's names & ages?

Occupation | Company/Employer Name

Do you have extended health insurance? ☐ Yes ☐ No

Amount of insurance per year (e.g. $500/year) | Renewal date (e.g. January 1)

Have you ever been under TCM and Acupuncture Care before? ☐ Yes ☐ No

Emergency Contact Name, Phone Number & Relationship to you

How did you hear about *What's Good*?

○ Referral ○ Website
○ Advertising ○ Other
(check one)

If you were referred, who may we thank for referring you?
If you heard about *What's Good* through an *OTHER* means, please specify

*Permission to Email ☐ Yes ☐ No

'What's Good' may contact me via email pertaining to appointments, promotions and general healthcare knowledge. It is not ***'What's Good's'*** policy to share email addresses with any third parties. I may opt-out at any time.

Symptoms & Signs (please check all that you are CURRENTLY experiencing)

Your Lifestyle

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Drugs
- ☐ Stress
- ☐ Occupational Hazards
- ☐ Exercise — Frequency:
  Type:

General Symptoms

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Dream disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Tingling or numbness
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweats easily
- ☐ Muscle cramps
- ☐ Vertigo
- ☐ Dizziness
- ☐ Bleed or bruise easily
- ☐ Abnormal taste in the mouth (specify):

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Sinus problems
- ☐ Excessive phlegm
- ☐ Colour:
- ☐ Earaches
- ☐ Sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Other:

Respiratory

- ☐ Difficulty breathing when lying down
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Asthma/wheezing
- ☐ Cough
  - ☐ Wet
  - ☐ Dry
  - ☐ Thick
  - ☐ Thin
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Other:

Cardiovascular

- ☐ High blood pressure
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Tachycardia
- ☐ Heart palpitations
- ☐ Irregular heartbeat
- ☐ Other:

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Regurgitation
- ☐ Gas
- ☐ Hiccup
- ☐ Bloating
- ☐ Bad breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use
- ☐ Black stools
- ☐ Bloody stools
- ☐ Mucous in stools
- ☐ Other:
- ☐ Intestinal pain or cramping
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Rectal pain
- ☐ Hemorrhoid
- ☐ Anal fissures

Bowel movements:
Frequency: Texture/form:
Colour: Odour:

Musculoskeletal

- ☐ Neck/shoulder pain
- ☐ Muscle pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Rib pain
- ☐ Limited range of motion
- ☐ Limited use:
- ☐ Other:

Skin & Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair loss
- ☐ Change in hair/skin texture
- ☐ Fungal infections
- ☐ Other:

Neuropsychological

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Abuse survivor
- ☐ Considered/attempted suicide
- ☐ Seeing a therapist
- ☐ Other:

Genito-urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Incomplete urination
- ☐ STD/STI
- ☐ Bedwetting
- ☐ Wake to urinate
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Kidney stone
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission

Gynecology

Age menses began:
Duration of flow:
Length of cycle:
Date last period began:

- ☐ Irregular periods
- ☐ Painful periods
- ☐ Clots
- ☐ PMS

Date of last PAP:

- ☐ Pregnant
- ☐ Possibly Pregnant
- ☐ Vaginal sores
- ☐ Vaginal discharge
  Colour:
- ☐ Breast lumps
- # Pregnancies:
- # Live births:
- # Premature births:
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Cysts
- ☐ Menopause
  Age at menopause:

Major Complaint(s), in order of significance to you and length of time with complaint (eg. Back pain for 2 years):

1 _____

2 _____

3 _____

4 _____

Besides getting rid of the abovementioned complaints, what is your main reason for wanting to get better/be healthy? (eg. live easier, for my family, to live longer, etc.)

_____

On a scale of 1 to 10 (10 being the highest), how committed are you to improving your health? (circle number):

1 2 3 4 5 6 7 8 9 10

In your entire life, what were your five most serious physical or emotional traumas or stresses? (eg. car accident, surgery, work stress, loss of a loved one, sports, fractures, abuse, depression, addictions, fears, etc.)

	Physical or Emotional Trauma/Stress	Date of Trauma
1		
2		
3		
4		
5		

Name of your primary Physician: _____

Other Practitioners being seen: _____

What do you like MOST about your previous Acupuncturist, Physician, other Practitioner(s)?

_____

What do you like LEAST about your previous Acupuncturist, Physician, other Practitioner(s)?

_____

Medications you are currently taking:

	Name of medication:	For the treatment of:
1		
2		
3		
4		
5		

Supplements you are currently taking (eg. vitamins, minerals, herbs, etc.)

Known or suspected sensitivities, and/or intolerances:

Additional information that you would like to share (all your information is kept confidential and private):

Consent to New Patient Exam & Treatment

I understand that acupuncture and other Traditional Chinese Medicine modalities are safe and effective for the prevention and treatment of a wide range of health problems, and for the promotion of general well being. I understand that acupuncture is not a substitute for conventional medical diagnosis and treatment provided by a medical doctor. I am aware that the acupuncturist does not diagnose illnesses or diseases and does not prescribe medications.

I have informed the acupuncturist of all my known physical and emotional conditions, medical conditions and medications, and I will keep the acupuncturist updated on any changes. If I experience any pain or discomfort during the session, I will immediately communicate that to the acupuncturist so the treatment can be modified.

I understand that occasional bruising and post-needling sensation may happen, as well as mild side effects such as fatigue and pain. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. I realize no claims, promises or guarantees are being made, and I accept full responsibility for the risk and effectiveness of all treatment. I understand that certain medications and social habits may decrease the beneficial effects of acupuncture Chinese herbs.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I understand that the purpose of today's first visit is to determine if I am a candidate for Traditional Chinese Medicine & Acupuncture care and that I am responsible for any fees agreed upon between myself and the practitioner. All examination fees will be explained to me before any tests are performed. I intend this consent form to cover the entire course of present and future care.

Patient's Printed Name

Patient's Signature (or Parent/Guardian's Signature)

Date Signed

Witness

Wellness by Design