TCM and Acupuncture Patient History

Name: _____
Address: _____
Postal Code: _____
Occupation: _____
Email: _____

Home Phone: _____
Work Phone: _____
Other Phone: _____
Birthdate: _____
Day/Month/Year

Please describe your concern. What is your chief complaint?

_____

_____

Is there anything that provides relief? Please describe.

_____

_____

Are you taking any medications? If so what are they and what are the dosages? This includes all over the counter medicines , supplements and birth control.

_____

_____

Have you had any major surgery, illness, accident or injury? If yes please explain.

_____

_____

Do you have any allergies? Please list. (ie. food, medication, environmental)

_____

_____

Have you been treated by any of the following in the last two years?

__Physician
__Chiropractor
__Osteopath
__Naturopathic Doctor
__Naturopath
__Physiotherapist
__Massage Therapist

Reason for Treatment:_____

Please check any areas that are a concern for you.

Pain:

__Headaches
__Upper Back Pain
__Lower Back Pain
__Neck
__Abdomen Pain
__Chest Pain
__Arm Pain
__Shoulder Pain
__Leg Pain
__Hip Pain
__Ankles
__Feet

History of current illness or dysfunction:

__Heart Conditions
__Fainting or Dizziness
__Menstrual Problems
__Whiplash
__Hypertension
__Circulatory Conditions
__Cancer
__Arthritic Conditions
__Respiratory Conditions
__Allergies
__Osteoporosis
__Skin Irritations or Conditions
__H.I.V.
__Fibromyalgia
__Stomach or Digestive Tract Disorders
__Numbness
__Depression
__Anxiety
__Blood Pressure
__Rheumatism
__TMJ Disorder
__Neurological Problems
__Stroke
__Diabetes
__Cholesterol
__Insomnia
__Chronic Pain

I _____ hereby request and consent to acupuncture and traditional Chinese medicine treatment and other such procedures as deemed necessary within the scope of Dr. Lisa James practice. As such any treatment to be performed upon myself I am held legally responsible.

Signed _____ Dated _____