

PROMEDMA Clinic

#102 9807 34 ave
Edmonton, AB T6E 5X9
780-468-6878
info@promedma.com

Date: _____

ACUPUNCTURE PATIENT INFORMATION

Full name: _____
Address: _____
City: _____ Postal Code: _____
Phone: (C) _____
Date of Birth M/D/Y: _____
Physicians name: _____ Phone: _____
Other health care practitioner's name: _____ Phone: _____
Other Treatment types received/reason: _____
Emergency Contact: _____ Phone no: _____
Relationship to Patient: _____
Email Address for appointment reminders: _____
Employer and Occupation: _____
Benefits Provider: _____
How did you hear about us? _____
Have you had Acupuncture before? if so when: _____
Allergies: _____

PATIENT HISTORY

Medications: _____
Injuries: _____
Surgeries: _____
Primary Complaint: _____
Is this a work related injury, WCB claim? YES _____ NO _____
If YES, Have you reported this to your Physician and WCB, Date of injury, and what happened? _____

Is this a MVA (Motor Vehicle Accident) YES _____ NO _____ Date of MVA _____
Claim # _____ Adjuster Name and phone # _____

**PATIENT HISTORY PLEASE
CHECK OFF ANY CONDITIONS THAT APPLY
TO YOU**

APPETITE

- Excessive
- Good
- Fair
- Poor
- Absent

DO YOU HAVE ANY FOOD CRAVINGS?

- No
- Yes
- If yes, specify: _____

HEADACHES

- Chronic Daily Headache
- Cluster
- Headaches
- Migraines
- Rebound
- Sinus
- Tension

BLOOD

- Anemia
- Bleeding Disorder
- Haemophilia
- Hepatitis
- HIV
- HIV/AIDS
- Hypercoagulability
- Polycythemia
- Thrombosis/Embolism

CARDIOVASCULAR

- Acute Coronary Syndrome
- Aneurysm
- Atherosclerosis
- Blood Clots-current _____ past _____
- Cardiac Arrhythmia
- Cardiovascular Accident
- Cardiovascular Conditions
- Chronic Ischemic Heart Disease
- Chronic Venous Insufficiency
- Cold Feet-left _____ right _____
- Cold Hands-left _____ right _____
- Congenital Heart Defect
- Congestive Heart Failure
- Coronary Artery Disease
- Fainting
- Heart Attack-when _____
- Heart Disease
- High Blood Pressure

- Hyperlipidemia
- Low Blood Pressure
- Lymphedema
- Lightheaded
- Myocardial Infarction
- Orthostatic hypotension
- Pacemaker
- Palpitations
- Pericarditis
- Phlebitis
- Raynaud Disease
- Rheumatic Heart Disease
- Valve Disorders
- Varicose Veins

EMOTION & MEMORY

- Alzheimer Disease
- Anxiety Disorder
- Mood Disorder
- Schizophrenia
- Stress
- Substance Use Disorder

ENDOCRINE

- Acute Pancreatitis
- Diabetes-Type _____
- Hyperthyroidism
- Hypothyroidism
- Pituitary and Growth Disorder

GASTROINTESTINAL

- Celiac Disease
- Constipation- current _____ past _____
- Crohn's Disease
- Diarrhea-current _____ past _____
- Digestive Conditions
- Diverticulitis
- Eating Disorder
- Esophageal Disorder
- Intestinal Polyps
- Irritable Bowel Syndrome (IBS)
- Stomach Disorder
- Ulcerative Colitis
- Nausea
- Vomiting
- Acid regurgitation
- Gas
- Hiccup
- Bloating after meals
- Intestinal cramping
- Laxative use
- Black stools
- Blood in stools
- Mucus in stools
- Undigested food in stools
- Stomach cramps

- Itchy anus
- Burning anus
- Rectal pain
- Hemorrhoids
- Enteritis
- Hard stools
- Bad breath
- Gurgling sounds
- # of bowel movements per day _____

HEARING

- Conductive Hearing Loss
- Ear Problems
- Hearing Loss
- Meniere Disease
- Motion Sickness
- Loss of balance
- Tinnitus
- Vertigo

IMMUNE

- Allergies-To what _____
- Anaphylaxis
- Cancer-current _____ past _____
- Hodgkin Lymphoma
- Infectious Mononucleosis
- Leukemia
- Lupus
- Non-Hodgkin Lymphoma
- Rheumatoid Arthritis

KIDNEY

- Bladder Disorder
- Chronic Kidney Disease
- Congenital Kidney Disease
- Electrolyte Imbalance
- Kidney Stones-current _____ past _____
- Renal Cysts
- Urinary Incontinence
- Urinary Tract Infection

MUSCULOSKELETAL

- Amyotrophic Lateral Sclerosis (ALS)
- Ankylosing Spondylitis
- Arthritis
- Artificial Joints/Special Equipment
- Bone Disease
- Compartment Syndrome
- Dislocation
- Fibromyalgia
- Fracture-when _____
where _____
- Gout Left _____ Right _____
- Hereditary/Congenital Deformity
- Jaw Pain (TMJD)
- Joint Injury-when _____
where _____

- Muscular Dystrophy
- Myasthenia Gravis
- Osgood-Schlatter Disease
- Osteoarthritis
- Osteomalacia
- Osteoporosis
- Paget Disease
- Psoriatic Arthritis
- Scleroderma
- Scoliosis
- Sinus Problems
- Strain/Sprain-when _____
Where _____

NEUROPSYCHOLOGICAL

- Abuse survivor
- ADHD
- Anxiety
- Brain Disorder
- Brain Injury
- Bell's palsy
- Burning-where _____
- Cerebral Palsy
- Cerebral Vascular Accident (Stroke)
- Chronic Pain Disorder
- Depression
- Dizziness
- Easily stressed
- Epilepsy
- Fainting
- Herniated Disc-where _____
- Huntington Disease
- Irritability
- Loss of Sensation-where _____
- Multiple Sclerosis
- Numbness- where _____
- Parkinson's
- Poor memory
- Seizure Disorder
- Shingles-current _____ past _____
- Stabbing-where _____
- Stroke-when _____
- Tingling-where _____
- Transient Ischemic Attacks (TIA)
- Trigeminal neuralgia
- Tics
- Vertebral and Spinal Cord Injury-When _____

REPRODUCTIVE

- Breast Disorder
- Ectopic Pregnancy
- Endometriosis
- Gynaecological Conditions
- Menopause
- Menstrual Cycle Disorder

- Ovarian Cysts/Tumors
- Pelvic Inflammatory Disease
- Pregnancy-how many_____
- # of children born_____
- Premenstrual Syndrome
- Uterine Disorder

RESPIRATORY

- Asthma
- Bronchitis
- Chronic Cough
- COPD
- Cystic Fibrosis
- Emphysema
- Infectious Respiratory Conditions
- Respiratory Conditions
- Respiratory Tract Infection
- Shortness of Breath
- Difficulty breathing lying down
- Productive cough with
 - A lot of sputum
 - Very little sputum
 - Sticky sputum
 - Green sputum
 - Clear sputum
 - Blood in sputum
- Chest pain
- Lightheaded
- Fast heartbeat
- Palpitations
- Orthostatic hypotension
- Phlebitis

SKIN

- Acne
- Alopecia/hair loss
- Allergic Dermatitis
- Athlete's Foot
- Brittle hair
- Bruise Easily
- Chemical Burn
- Dandruff
- Dry skin
- Eczema
- Fungal infections
- Hives
- Herpes
- Hypersensitive Reactions
- Itchy skin
- Infectious Skin Conditions
- Melanoma/Carcinoma
- Oily skin
- Pigmentary Disorder
- Planter's Wart Left_____ Right_____
- Premature gray hair

- Psoriasis
- Rash- Where_____
- Rosacea
- Shingles
- Skin Conditions
- Skin Irritations
- UV Burn- current_____ past_____
- Ulcerations

HEAD, EYES, NOSE AND THROAT

- Glasses
- Eye strain
- Red eyes
- Itchy eyes
- Spots in eyes
- "Floaters" in vision
- Poor vision
- Nose bleeds
- Blurred vision
- Night blindness
- Glaucoma
- Cataracts
- Grinding teeth
- Multiple cavities
- Ringing in ears
- Migraines
- TMJ
- Gum disease
- Sore gums
- Bleeding gums
- Sores on lips
- Sores on tongue
- Dry mouth
- Poor hearing
- Concessions
- Excessive saliva
- Sinus problems
- Clear throat often
- Recurrent sore throat
- Swollen glands
- Lumps in throat
- Enlarged thyroid
- Earaches
- Other

GENITO-URINARY CONDITONS

- Painful urination
- Frequent urination
- Copious urination
- Frequent kidney infections
- Cloudy urination
- Scanty urination
- Urination at night
- Urination incontinence
- Dark yellow urine
- Light yellow urine
- Clear urine
- Burning urination
- Retention of urine
- Frequent bladder infections

SLEEP PATTERNS

- Insomnia
- Troubles falling asleep
- Problems staying asleep
 - Times you wake at _____
- Wake up tired
- Dream disturbed sleep
- Nightmares
-

MISCELLANEOUS

- Insomnia
- Mental Illness
- Other Diagnosed Diseases _____
- Other Medical Conditions _____
- Surgical Pins or Wire-where _____
- Vision Loss
- Vision Problems

MALES ONLY

- Testicular pain
- Impotence/Erectile Dysfunction
- Sexually Transmitted Disease
- Prostate Problems

FEMALES ONLY

- Age of first Menses _____
- Duration of Menses (e.g. 3-5 days) _____
- Length of cycle (e.g. 28-30 days) _____

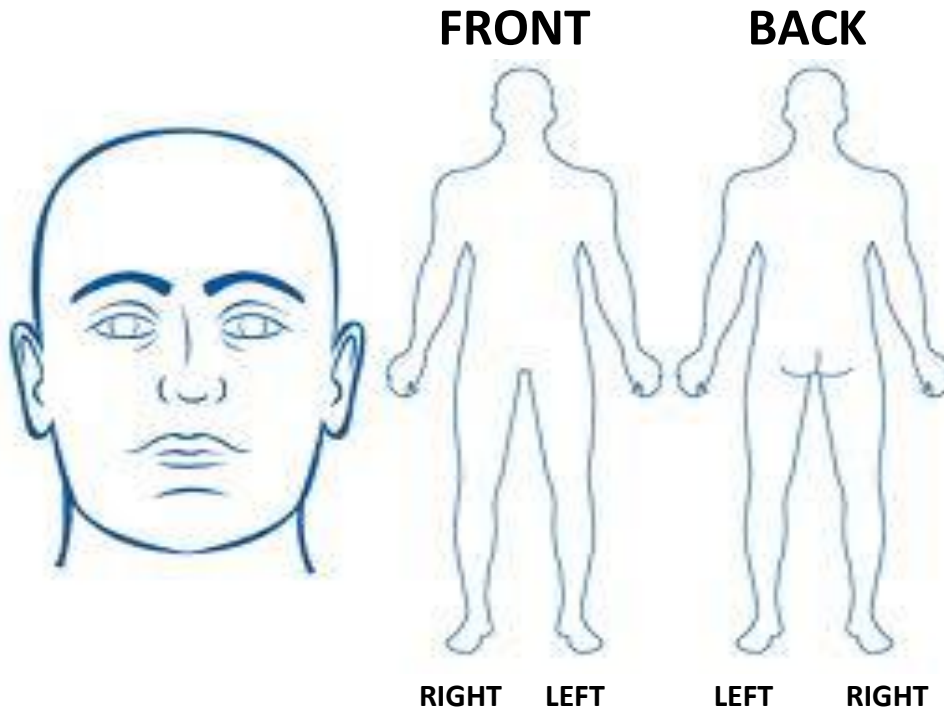
- Regular menses
- Pre-Menstrual Syndrome (PMS)
- Painful menses
- Clots
- Discharge
- Sexually Transmitted Disease
- Heavy/Excessive flow
- Spotting/Bleeding between cycles
- Menstrual problems
- Menopausal problems
- Breast lumps
- Birth control
 - No
 - Yes
 - Type _____
- Pregnant
 - No
 - Yes
 - Number of weeks _____
- Have you every been pregnant
 - No
 - Yes
 - # of pregnancies _____
 - # of Miscarriages _____
 - # of Abortions _____
 - Problems in Pregnancy
 - No
 - Yes
 - Problems in Delivery
 - No
 - Yes
- Other _____

Family History

Please state Father, Mother, siblings, child(ren)

- Arthritis _____
- Cardiovascular _____
- Respiratory _____
- Cancer _____
- Diabetes _____
- Heart disease _____
- Hypertension _____
- Stroke _____
- Epilepsy _____
- Mental illness _____
- Tuberculosis _____
- Other _____

Please indicate on diagram where you are experiencing any soreness, problems or concerns.



PLEASE CHECK BOXES RELEVANT TO YOU MUSCULOSKELETAL CONDITIONS

- | | |
|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Hand pain | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Finger pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Ankle pain |
| <input type="checkbox"/> Rib pain | <input type="checkbox"/> Toe pain |

Describe any concerns you have regarding your comfort and safety during an acupuncture treatments such as: needle phobia, bleeding disorders (e.g. haemophilia), pace maker, medication pump blood pressure, infections, compromised skin (e.g. lesions, cuts, burns).

Please read carefully

I, _____ do hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including: needling, moxibustion, cupping, gua sha, laser acupuncture, electro-acupuncture, and other techniques within the scope of practice of registered acupuncturists.

The registered acupuncturist named below may perform these procedures and/or anyone working in this clinic, authorized by the registered acupuncturist named below, in accordance with the Alberta Acupuncture Regulation.

I have had the opportunity to discuss the nature and purpose of acupuncture care and other procedures or alternative care with the registered acupuncturist and/or with other office or clinic personnel. I understand that results are not guaranteed.

I further understand and I am informed that, as in all health care, in the practice of acupuncture, even though all needles are pre-sterilized and disposable, there are some risks to treatment including but not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgement during the course of the procedures which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of client (print)

Signature of client

PRISCILLA TAO
Name of the Registered Acupuncturist

Signature of the Registered Acupuncturist

DATE

WHITNESS

***No tipping at PROMEDMA. Thank you for your understanding.