New Patient History for Acupuncture · Oakridge Chiropractic Centre

Name

Address | Postal Code

Phone: Home | Cell | Work

Email | Preferred contact for reminders ☐ H ☐ C ☐ W ☐ Email

Marital Status

Age | Birthdate | ☐ Male ☐ Female

Family Physician

Referred to our clinic by

Main Concern

How long have you had this problem? | Have you seen anyone else for this?

What makes it better? | What makes it worse?

Your Medical History:

Medications or vitamins

Surgeries

Diagnosed medical conditions

Drug and food allergies

Serious illness/hospitalizations

Family Medical History

☐ Asthma	☐ Anemia	☐ High Blood Pressure	☐ COPD
☐ Liver Disease	☐ Heart Attack	☐ Obesity	☐ Alcoholism
☐ Osteoporosis	☐ Arthritis	☐ Drug Addiction	☐ Thyroid Disease
☐ Lung problems	☐ Depression	☐ Kidney Disease	☐ Diabetes
☐ Cancer	☐ Stroke		

Please check any that apply to you and indicate how much

☐ Black Tea	☐ Coffee	☐ Pop	☐ Water
☐ Tobacco	☐ Alcohol	☐ Recreational Drugs	

How many meals to you eat a day? | How many snacks a day?

How much do you exercise?

Do you have trouble sleeping at night? ☐ No ☐ Yes

Please check any that apply to you

☐ Loose stools	☐ Insomnia	☐ Always feel hot	☐ Gas
☐ Disturbing dreams	☐ Night sweats	☐ Constipation	☐ Nightmares
☐ Hot flashes	☐ Belching	☐ Anxiety	☐ Bruise easily
☐ Heartburn	☐ Panic attacks	☐ Varicose veins/Spider veins	☐ Indigestion
☐ Depression	☐ Hemorrhoids	☐ Bloating	☐ Mental illness
☐ Uterine prolapse	☐ Easily tired	☐ Poor memory	☐ Anal prolapse
☐ Nausea	☐ Obsessiveness	☐ Ulcers	☐ Vomiting
☐ Dizziness	☐ High blood pressure	☐ Poor appetite	☐ Spots in vision
☐ Headaches	☐ Hearing loss	☐ Eye disease	☐ Migraines
☐ Ringing in ears	☐ Anemia	☐ Numbness	

(*continued on other side* ➔)