Parallel Chiropractic & Wellness Centre
Acupuncture & TCM New Patient Questionnaire

The following information is helpful to the diagnostic procedure and enables us to provide you with better treatment.

Name: ____ Date: ____________________

Address: ____ Postal Code: ____________________

Phone #: ________________________ Work/Cell #: ______________________ Gender: ☐*F* ☐ *M*

E-mail: ______________________________ As per CASL I consent to receive email correspondence ______ (initial)

Status S__ M__ W__ C/L__ Occupation: __________________________ Date of Birth: M__ D__ Yr_____

Emergency Contact Name ________________________________ Phone: ______________________

Doctor: ____ Phone: ______________________

Is this your first time getting acupuncture? ☐ *Yes* ☐ *No.* How did you hear about us? ______________________

Goals: What would you most like to achieve with acupuncture treatments?

____

____

____

Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(Most concerning to least, along with the duration of the symptom)

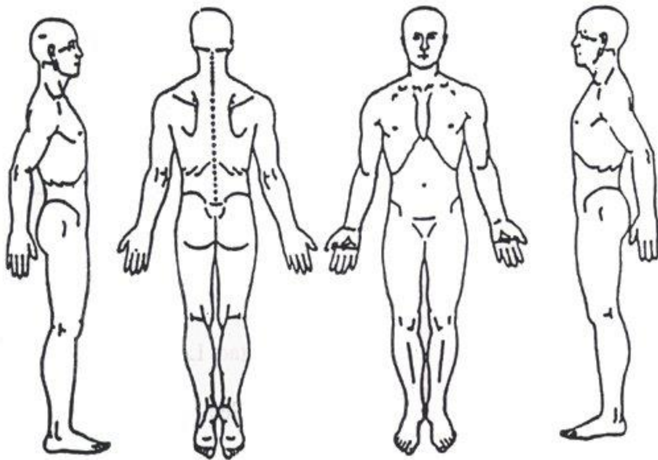
____

____

____

Experiencing pain/discomfort in any area of your body? ☐ *Yes* ☐ *No*

Please rate your pain level: < 1 2 3 4 5 6 7 8 9 10 > Duration of pain: ___________



Use the illustration to indicate painful or distressed areas.
Indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X *Sharp/Stabbing* **P P P** *Pins & Needles*

D D D *Dull/Aching* **N N N** *Numbness*

T T T *Tightness/Spasms*

Aggravating factors: (eg. Heat) _________________

Alleviating factors: (eg. Cold) __________________

All information will be treated in the strictest confidence.

Medical History
Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

Date Diagnosed	Date Diagnosed
Cancer (type)	Hepatitis
HIV	Stroke
Diabetes	Mental Illness
Heart Disease	Seizures
High Blood Pressure	High Cholesterol
Thyroid Disease	Other

Please list any surgeries or major injuries with dates.
____
____

List any medications or supplements you have taken in the last 2 months.
____
____
____

Do you have a pacemaker or any metal devices in your body? ☐ *Yes* ☐ *No.* If so, which: ______________________

Intolerant of, or allergic to: ☐Alcohol Swabs ☐Iodine ☐Coconut Oil ☐Other: ___________________________

Family History
Indicate close family members with any of the following:

Cancer (specify type)	High Cholesterol
Diabetes	Mental Illness
Heart Disease	Stroke
High Blood Pressure	Alcoholism

Lifestyle Habits

Do you have an exercise routine? ☐ *Yes* ☐ *No*
Please describe
____
____
____

How many hours per night do you sleep on average? __________ Do you wake rested? ☐ *Yes* ☐ *No*

Nicotine Use: __________________ Alcohol Use (#drinks/week and type):____________________________________

Caffeine Use (#drinks/day and type): ____________________Water intake (how much/day): ____________________

Briefly describe your dietary habits (#meals/day; type of food; snacks; sweet tooth)

____

____

____

Energy: How is your energy? Please circle. Low < 1 2 3 4 5 6 7 8 9 10 > High

What time of day is your energy:

Highest: ☐*6am-12pm* ☐*1pm-5pm* ☐*6pm-12am* Lowest: ☐*6am-12pm* ☐*1pm-5pm* ☐*6pm-12am*

Do you fatigue easily? ☐ *Yes* ☐ *No*

How do you feel emotionally?

____

____

Emotions: How are your stress levels? Please circle. Low < 1 2 3 4 5 6 7 8 9 10 > High

Do you have: ☐ *Panic attacks* ☐ *Depression* ☐ *Anxiety/Worry* ☐ *Irritability* ☐ *Nervousness*

☐ *Fear attacks* ☐ *Mood Swings* ☐ *Difficulty Making Decisions* ☐ *Poor memory* ☐ *Difficult concentration*

☐ *Suppressing Emotions* ☐ *Frequent Sighing* ☐ *Easily Startled*

Bowel movements:
How often?___time(s) a day, or __ time(s) a week

☐ Irregular Bowel Movements
☐ Painful bowel movements
☐ Haemorrhoids
☐ Hard stools
☐ None of the above
☐ Constipation
☐ Undigested food in stools
☐ Itchiness
☐ Blood in stools
☐ Diarrhoea
☐ Burning sensation
☐ Loose stools
☐ Gas

Urination:
How often?______times per day Color: ☐ Pale yellow ☐ Dark yellow/orange

I have or had:
☐ Trouble starting stream
☐ Dribbling when sneezing
☐ Kidney Stones
☐ Frequent urination
☐ Burning Pain
Other____________
☐ Incontinence
☐ Frequent UTIs
☐ None of the above

Please tick symptoms you have or have had in the past year:

Energy and Immunity
☐ Fatigue
☐ Chronic Fatigue Syndrome
☐ Fibromyalgia
☐ Anemia
☐ Thyroid Problems
☐ Multiple Sclerosis
☐ Allergies (which?)___________
☐ Tendency to Catch Colds
☐ Other Autoimmune __________

Head, Eye, Ear, Nose, and Throat
☐ Eye Dryness
☐ Poor Night Vision
☐ Ringing in Ears
☐ Teeth Grinding / TMJ
☐ Dry Mouth
☐ Bleeding Gums
☐ Headaches / Migraines
☐ Eye Floaters or Spots
☐ Cataracts
☐ Hearing Difficulties
☐ Sore Throat
☐ Bad Breath
☐ Loose Teeth
Frequency: ____________
☐ Blurry Vision
☐ Glaucoma
☐ Ear Pain or Discharge
☐ Chronic Sinus Congestion
☐ Mouth Sores / Ulcers
☐ Increase in Thirst
Location: ________________

Respiratory/Cardiovascular

☐ Shortness of Breath ☐ Asthma ☐ Chest Pain
☐ Heart Palpitations / Fluttering ☐ Poor Circulation (Cold hands/feet) ☐ Chronic Cough
☐ Night Sweats ☐ Unusual Sweating ☐ Varicose or Spider Veins
☐ Sensitive to the cold ☐ Sensitive to heat

Gastrointestinal

☐ Ulcers ☐ Changes in Appetite ☐ Nausea / Vomiting
☐ Belching ☐ Bloating / Pain ☐ Gas
☐ Heartburn / Acid Reflux ☐ Sudden Weight Change ☐ Food / Flavour Cravings: _______
☐ Special Diets: (eg/ vegan, gluten free …) ________________________________ ☐ Gall Stones / Gallbladder attack

Skin

☐ Rashes/Eczema/Hives/Psoriasis ☐ Changes in Skin Colour ☐ Easy Bruising
☐ Acne ☐ Dry / Itchy Skin ☐ Dry Hair or Hair Loss
☐ Brittle Nails

Sleep

☐ Insomnia ☐ Nightmares ☐ Excessive Dreaming
☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Waking Up Early
☐ Restless Sleep

Neurological

☐ Vertigo / Dizziness ☐ Numbness / Tingling ☐ Poor Concentration or Memory

Musculoskeletal

☐ Neck / Shoulder Pain ☐ Muscle: Spasms/Cramps/Weakness
☐ Arm Pain ☐ Finger Pain / Tingling / Numbness
☐ Upper Back Pain ☐ Mid Back Pain ☐ Low Back Pain
☐ Hip / Pelvic Pain ☐ Leg / Knee Pain ☐ Foot / Ankle Pain
☐ Arthritis

Men's Health

☐ Prostate Enlargement ☐ Erectile Difficulties ☐ Decreased Libido
☐ Swelling/Lumps in Testes ☐ Impotence ☐ Premature Ejaculation

Women's Health:

Currently Pregnant? ☐ *Yes* ☐ *No* Number of pregnancies: _________
Currently on birth control? ☐ *Yes* ☐ *No* Method Used: ______________
Age of first menses: ____________ Number of days in cycle: ________ ☐ Irregular Cycle
Number of flow days: ___________ ☐ Heavy Flow ☐ Light Flow
Typical Color: ☐ dark red
☐ bright red
☐ pale red

☐ Vaginal discharge. Colour?_____ ☐ Unusual Vaginal Discharge Odor ☐ Mid-cycle mucus

☐ Strong PMS symptoms ☐ Irritability ☐ Breast Tenderness
☐ Cravings ☐ Cramps ☐ Clots in Menstrual Blood
☐ Menstrual Related Moodiness ☐ Menstrual Related Bloating ☐ Bleeding Between Cycles
☐ Painful Periods ☐ before ☐ during ☐ after
☐ Vaginal Dryness ☐ Breast Lumps / Cysts ☐ Uterine Fibroids
☐ Endometriosis ☐ Ovarian Cysts ☐ Frequent Yeast Infections
☐ Hot flashes ☐ Decreased Libido

Acupuncture Appointments

Please bring this completed new patient questionnaire with you to your first appointment.

Please eat a light meal or snack before your appointment; an empty stomach may cause dizziness.

Please do not eat or drink food that may change the color of your tongue or brush your tongue the day of your appointment. (coffee, fizzy drinks, juice, liquorice, beetroot, etc)

What to expect at your first visit?

Your first visit will take about one hour and will include an acupuncture treatment. We will discuss your health questionnaire and any concerns you have prior to the treatment. I will make a diagnosis, a treatment plan and may give a few suggestions regarding your condition. If you have any questions please do not hesitate to email or call me.

Waiver & Consent to Treatment

Payment is due at time of service for all patients. A fee will be charged for missed appointments or cancellations without a 24-hour notification.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, heat lamps, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be unpleasant in smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days. and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion or when treatment involves the use of heat lamps. Bruise-like skin discolouration is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhoea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I experience any side effects or if I am or become pregnant.

Alberta acupuncture legislation states that an acupuncturist must not treat someone who has not consulted with a physician, or in the case of dental pathology a dentist, about the condition for which he/she is seeking care and treatment. Please initial the applicable box confirming that you have already seen a physician, or will be seeing one within 2 weeks of your first acupuncture treatment.

______ I have already seen a doctor regarding the condition(s) that I am seeking treatment for.
______ I agree to see a doctor regarding the condition(s) that I am seeking treatment for within 2 weeks of my first appointment

____ ____________________
Signature Date

____
Please Print Name

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