HEALTH INFORMATION FORM

Name **Personal pronoun**

Date of Birth **Alberta Health Care #**

Address

Postal Code **Email**

Phone (home) **(cell)**

Emergency contact name **Phone**

What is your current health concern?

*When did this problem start?

*Is it… Getting worse ☐ Constant ☐ Comes and goes ☐ Getting better ☐

***Family Medical History**

***Past Medical History**

Approximate age of parents at your conception

Problems in pregnancy/delivery

Major illnesses since birth

***Surgeries**

Name of your family doctor and/or specialist

Are you actively under your doctor's care? Yes ☐ No ☐

Did a health care practitioner refer you here?

If so, would you like for me to send progress notes?

*_Are you …_ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐

Known allergies

Medications or nutritional supplements you are currently taking

Do you get …

fever and/or chills ☐ unusual sweating ☐ unusual odors/discharge ☐

Current habits (eg. coffee, alcohol, smoking, drugs)

Significant stresses (please list)

Describe your night-time sleep (any difficulty getting to or staying asleep?)

Head/Neck

Problems with your senses (ie. hearing, taste, smell, touch, odd taste/smell)

Difficulties with your head/neck

Chest

Cough/phlegm? Breathing problems?

Heart palpitations, chest pain?

Blood pressure concerns?

Gastrointestinal

How often do you eat?

Do you have regular meals?

How is your appetite?

Any recent change in your appetite?

Kinds of food you are eating

Indigestion? (ie. bloating, gas, bad breath, burping)

Bowel movements? (ie. how often, constipated, loose; unusual odor/color)

Genitourinary

Problems with your urine/urination

Do you have to get up at night to void? (if yes, how often?)

Reproductive

Are you sexually active? If yes, are there any difficulties or problems?

Females: Number of pregnancies Number of births

Current type of birth control, if any

Most recent PAP test

Any abnormalities noted?

Are you menstruating?

If no, when did it stop?

If yes, is it regular or irregular?

How many days is your cycle?

Is there significant pain? Clots?

Color of discharge

Musculoskeletal/Neurological

Describe any aches, pains, or weird sensations anywhere on your body

Have you ever sustained any physical injuries as a result of an accident? If yes, please describe when and where it happened, injuries sustained, treatment received, and residual limitations.

*Are you engaged in any legal action?

Describe your energy level

Sudden energy drop at what time

Skin

Problems with your skin (eg. rashes, eczema, pimples, itching)

Swelling in hands/feet?

Anything else you would like for me to know?

*Client Declaration

I hereby declare that the above information is correct and that I have not withheld any medical information specifically requested.

I understand that acupuncture is not covered under Alberta Health Care and therefore I am responsible to pay for all costs incurred per visit. Payment is to be made with cash, e-Transfer or cheque (payable to Dr. Alice Wong) on the date of service.

I also understand that there is a 24 hour cancellation policy in effect. With any late cancellation or absence of a booked appointment, a fee will automatically be billed to my account. No further treatment will be provided until any such fees are paid.

Client's Name

Client's Signature
(typing your name is sufficient if you are unable to digitally sign)

Date

Revised 04/23