Acupuncture Patient Health History Form

Moore Chiropractic Health Centre
5912 Hazeldean Rd, Stittsville, ON, K2S 1B9
613-831-8374

Patient Information				
First Name:		Last Name:		Middle Name:
Telephone (Home/Mobile):		Telephone (Business):		Sex: M / F / Other
Home/Street Address:		Apt #:		Date of Birth: (DD/MM/YY)
City:	Province:	Postal Code:		Marital Status:
Occupation:		Email:		
Emergency Contact Information		First name:		Last name:
Relationship to Patient:		Phone Number:		Mobile Number:
Family Doctor Name:				
Clinic Address:				
Clinic Phone:		Clinic Email:		

Past Medical History

Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.

Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment

Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.

Please select any conditions you are experiencing (past and present):

General Symptoms
- ☐ Headaches/migraines
- ☐ Fever
- ☐ Chills
- ☐ Sweat
- ☐ Memory loss
- ☐ Dizziness/Light headiness
- ☐ Fainting
- ☐ Stress/depression
- ☐ Discoordination
- ☐ Nervousness
- ☐ Recent weight loss/gain
- ☐ Numbness pain in arms, legs
- ☐ Frequent colds

Muscle and Joint
- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Pain in shoulder
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Arthritis
- ☐ Foot trouble
- ☐ TMJ/Jaw trouble

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ High cholesterol
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Pain over heart
- ☐ Previous stroke or TIA
- ☐ Previous heart attack
- ☐ Palpitations

Respiratory
- ☐ Wheezing
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficulty breathing

Ears, Eyes, Nose, Throat
- ☐ Deafness
- ☐ Ringing in ear(s)
- ☐ Earache
- ☐ Ear discharge
- ☐ Vision problems
- ☐ Glaucoma
- ☐ Eye pain
- ☐ Floaters
- ☐ Red/itchy eyes
- ☐ Tearing/dry eyes
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Hay fever
- ☐ Asthma
- ☐ Dental decay
- ☐ Gum trouble
- ☐ Tonsillitis
- ☐ Enlarged glands

Gastrointestinal
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Distress from greasy foods
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Burning in stomach
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon trouble
- ☐ Blood in stool
- ☐ Mucus in stool
- ☐ Liver trouble/hepatitis
- ☐ Gall bladder trouble
- ☐ Ulcers
- ☐ Colitis
- ☐ Hemorrhoids
- ☐ Hypoglycemia
- ☐ Hiatal hernia
- ☐ Metallic taste

Skin
- ☐ Skin conditions/rashes
- ☐ Itching
- ☐ Dryness
- ☐ Boils
- ☐ Sensitive skin
- ☐ Hives or allergy
- ☐ Bruise easily
- ☐ Varicose veins

Genitourinary System
- ☐ Frequent/painful urination
- ☐ Blood in urine
- ☐ Inability to control urine
- ☐ Bladder infection
- ☐ Kidney infection
- ☐ Kidney stone(s)

For Women Only
- ☐ Pregnant
- ☐ Cramps/backache
- ☐ Irregular cycle
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Breast tenderness
- ☐ Vaginal discharge
- ☐ Menopausal symptoms
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Hysterectomy
- ☐ Previous miscarriage

Have you had any of the following?

☐ Appendicitis	☐ Malaria	☐ Chicken pox	☐ Alcoholism	☐ Osteoporosis
☐ Diabetes	☐ Venereal infection	☐ Cold sores	☐ Whooping couch	☐ Cancer
☐ Epilepsy	☐ Multiple sclerosis	☐ Anemia	☐ Heart disease	☐ Tuberculosis
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Eczema	☐ Mental illness
☐ Mumps	☐ Influenza	☐ Gout	☐ Polio	☐ Pleurisy

Are you taking any blood thinners? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No
Do you have seizures? ☐ Yes ☐ No

Signature of Patient: ____________________ **or Substitute Decision-Maker:** ____________________

Date: ______________________________ **Relationship to Patient:** ______________________