Sacred Meridian Acupuncture
Confidential Patient Information

Name: _____
Date of birth: _____ Age:_____
Address: _____ Email:_____
Phone # hm:_____ wk:_____ cell_____

Kind of Employment: _____
Name of doctor/midwife: _____
Emergency contact: _____Phone:_____
How did you find me? _____
Are you taking any medications? Dosage: _____
_____
Supplements/ Herbs :
_____
Pregnancy related questions:
How many weeks are you? _____
Your estimated due date?_____
Pregnancy relate
concerns:_____
_____

Health concerns for your visit today:
_____
_____
_____
History and details of concerns:
_____
_____

Previous medical history:

Previous illnesses: _____
(Adult or childhood)
_____

Surgeries: _____

Traumas: (physical or emotional)
_____
_____

Family Health Status:

TB	Cancer
Heart disease	Asthma
Peptic Ulcer	Kidney disease
Diabetes	Stroke
High Blood Pressure	Mental/Emotional problems

Epidemic _____ HIV_____ Hepatitis_____

Do you have any occupational or family related stress?
_____

What kind of dietary and exercise habits do you have?

_____
_____

If there are any questions or concerns please feel free to discuss them, I want to make this visit a pleasant and relaxing experience for you.

If you need to reschedule please allow 24 hour notice before your appointment.

Patient signature: _____

Date:_____

Patient Symptoms and Evaluations

Check the box when you experience the symptom
Please indicate symptoms that are current (c) or past (p)

When answering the following please rate with a number
"1" occasionally, mildly
"2" frequently, moderately severe
"3" disabling or persistent

Headache and Dizziness

Headaches that have :
□ radiating pain
□ dull pain
□ sharp pain

Location

□ forehead
□ occipital (base of the skull)
□ at the temples
□ top of head

Dizziness □ yes □ no
how frequent?
Blood pressure_____ mmhg

Hair and Skin

□ Hair falls out frequently
□ premature graying
□ dry hair
□ oily hair

□ skin rashes
□ dry skin
□ easily bruised
□ acne
□ other

Ears Nose Throat and Mouth

□ history of earaches
□ tinnitus/ ringing of the ears
□ high pitched
□ low pitched
□ abnormal ear discharge
□ vertigo/ difficulty keeping balance

□ nosebleeds
□ history of sore throats
□ frequently blow your nose (even when you aren't sick)
□ swollen glands

Eyes and Mouth

□ eye pain / swelling
□ blurry vision / visual spots
□ red, itchy eyes

□ do you clench your jaw?
□ experience foul breath
□ bleeding in the gums

Chest and Cough

□ dry cough □ with phlegm
□ shortness of breath / wheezing
□ asthma
□ frequent colds

□ burning chest pain
□ rapid heart beat
□ distending/ chest fullness
□ chest tightness
□ palpitation / feel your heart beat abnormally
Do you experience anxiety?

Digestion

□ belching □ nausea
□ indigestion □ esophageal reflux
□ hiccup □ vomiting □ gas

Stomach pain

□ burning □ distending (moves around)
□ dull pain
□ pain after eating

Appetite

□ decreased
□ increased

Bowel Movement:

frequency ____

Constipation:

□ yes
□ dry stool
□ difficult to expectorate

Diarrhea

□ yes
□ watery stool
□ foul odor stool
□ abdominal pain following stool
□ undigested food in the stool
□ at dawn

Urination

Frequency(relative to intake)

□ low (6 per day)
□ high (8 per day)

colour:

□ clear

□ dark

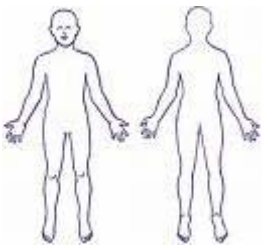
Painful urination □ yes □ no

Difficulty holding □ yes □ no

Incontinence (leaking) □ yes □ no

Enuresis(inability to control urine especially during the night)
□ yes □ no

Muscles and Joints please circle and indicate the area of pain and swelling



□ heavy sensation over body and limbs
□ low back pain
□ knee soreness
□ numbness or tingling

Body Temperature:

□ alternating fever and chills
□ dislike of heat
□ dislike of cold
□ night sweats
□ daytime sweats

Sexual Energy

□ increased □ decreased

Female Section :

Menopause □ yes □ no
If yes, when was your last cycle?_____

Menstruation: When was you first day of your last cycle? _____

cycle: □ regular □ early
□ delayed □ irregular

How many days of bleeding is your cycle? ___

Quantity	□ heavy □ light	
color	□ bright/ fresh blood red □ light pink red	□ dark/ black red
property	□ stringy clots □ thick with (quarter sized clots)	
cramps	□ yes	□ no

Do you take medication or herbs for the pain? _____

amenorrhea (absence of period)	□ yes	□ no

When was your last cycle?

spotting (in between periods)	□ yes	□ no

Leukorrhea with white/yellow discharge □ yes □ no

Pregnancy

Are you pregnant/ trying to get pregnant □ yes □ no

How many children do you have? _____

Normal delivery?	□ yes	□ no
Miscarriages	□ yes	□ no

General Information

Energy level	□ low	□ high
Sleep	□ difficulty falling asleep □ Wakes frequently through the night	
Weight	□ loss	□ gained
Thirst	□ usually	□ seldom

Is there a prominent emotion that you experience that may be a sign of imbalance?

□ sadness	□ anger/frustration
□ depression	□ other

Thank you for taking the time to fill out these forms, they will help me see a clear picture of your overall diagnosis for Traditional Chinese Medicine.