



**CONFIDENTIAL CASE HISTORY
ACUPUNCTURE
FILOSOFI HOLISITIC HEALTH CENTRE**

Name: _____ Date: _____ Male Female Date of Birth: _____

Address: _____ City/Province/Postal Code: _____

Phone number: _____ Alternate Number: _____

Marital Status: Married Domestic Partner Single Divorced Widowed # of children _____

Email address: _____

Occupation: _____

How did you hear about us? _____

Have you received Acupuncture therapy before? Yes No

Medical Doctor's Name: _____ Doctor's Address: _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

<u>Illness</u>	<u>You</u>	<u>Your Relative</u>	<u>Approx. Date</u>	<u>Illness</u>	<u>You</u>	<u>Your Relative</u>	<u>Approx. Date</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexually Transmitted Diseases: Gonorrhea Syphilis AIDS HPV Chlamydia Herpes Date: _____

List any medications and supplements you are currently taking:

<u>Medicine/Supplement</u>	<u>Dosage</u>	<u>Reason</u>	<u>Length</u>	<u>Date of Last Checkup</u>

What are the main problems for which you are seeking treatment? _____

What other forms of treatment have you sought? _____

List any other health problems you now have. _____

List any allergies, food sensitivities or food craving that you have. _____

List any accidents, surgeries, or hospitalizations (including date). _____

The following is a list of symptoms that you may or may not have ever experienced. Please indicate as follows:
No mark () = never experienced **check mark (√)** = sometimes experience **plus sign (+)** = frequently experience

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> jaundice | <input type="checkbox"/> anemia |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> mentally restless | <input type="checkbox"/> difficulty digesting | <input type="checkbox"/> hair loss |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> chest pain | <input type="checkbox"/> oily foods | <input type="checkbox"/> asthma |
| <input type="checkbox"/> digestive problems | <input type="checkbox"/> sciatic pain | <input type="checkbox"/> low back pain | <input type="checkbox"/> tendency to catch colds |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> headaches | <input type="checkbox"/> knee problems | <input type="checkbox"/> easily |
| <input type="checkbox"/> belching, burping | <input type="checkbox"/> cough | <input type="checkbox"/> easily angered or | <input type="checkbox"/> intolerance to weather |
| <input type="checkbox"/> heartburn/reflux | <input type="checkbox"/> kidney stones | <input type="checkbox"/> agitated | <input type="checkbox"/> changes |
| <input type="checkbox"/> feeling the retention of | <input type="checkbox"/> cold hands and feet | <input type="checkbox"/> difficulty in making | <input type="checkbox"/> allergies |
| <input type="checkbox"/> food in the stomach | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> plans or decisions | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> nasal problems | <input type="checkbox"/> skin problems | <input type="checkbox"/> easily bruised | <input type="checkbox"/> tendency to faint easily |
| <input type="checkbox"/> tendency to become | <input type="checkbox"/> feeling of claustrophobia | <input type="checkbox"/> edema | <input type="checkbox"/> high cholesterol levels |
| <input type="checkbox"/> obsessive in work, | <input type="checkbox"/> bronchitis | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> hearing impairment |
| <input type="checkbox"/> relationships... | <input type="checkbox"/> spasms or twitching | <input type="checkbox"/> nightmares | <input type="checkbox"/> ear ringing |
| <input type="checkbox"/> colitis or diverticulitis | <input type="checkbox"/> of muscles | <input type="checkbox"/> sudden weight loss | <input type="checkbox"/> recent use of antibiotics |
| <input type="checkbox"/> constipation | <input type="checkbox"/> gall stones | <input type="checkbox"/> fatigue | <input type="checkbox"/> urinary problems |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> eye problems | <input type="checkbox"/> heart palpitations | |

How do you FEEL about the following areas of your life?

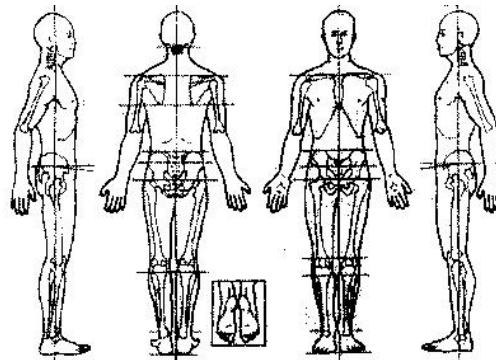
Please check the appropriate boxes and indicate any problems you may be experiencing:

	<u>Great</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Bad</u>	<u>Your Comments</u>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

MUSCLE PAIN AND TENSION

- | | | | | |
|--|--|--|--|---|
| Neck | Shoulders | Arm | Leg | Back |
| <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> upper <input type="checkbox"/> mid |
| <input type="checkbox"/> front <input type="checkbox"/> back | <input type="checkbox"/> front <input type="checkbox"/> back | <input type="checkbox"/> front <input type="checkbox"/> back | <input type="checkbox"/> front <input type="checkbox"/> back | <input type="checkbox"/> lower |

Please indicate the areas you are experiencing pain or discomfort on the diagrams to the right.



I understand and agree that the information I have provided is accurate, current and will be confidential. If at any time there is any change to my health status I will let my Practitioner know as soon as possible.

Please go to our website www.filosofi.ca to see our complete Privacy Policy.

Signature: _____ Date: _____

Note: Any appointment missed or cancelled with less than 12 hours notice will be charged at the full price of the service.