CALDWELL ACUPUNCTURE CLINIC Confidential Patient Information

Phone: 604-618-3111 Email: drhc@shaw.ca

NAME _____ **Date** _____ **M__ F__**

Home Phone _____ Work Phone _____ Email _____
Birth date (M) ____ (D) ____ (Y) _____ Height _____ Weight _____ Occupation _____
Street _____ City _____ Prov. _____ Postal Code _____

YOUR MEDICAL HISTORY

□Cancer □High Blood Pressure
□Hepatitis □Heart Disease
□Thyroid Disease □Diabetes
□Rheumatic Fever □Other

FAMILY MEDICAL HISTORY

□Cancer □Alcoholism
□Diabetes □Stroke/Seizure
□Asthma □Allergies □Heart Disease
□High Blood Pressure □ Other

HABITS

□Alcohol □Cola
□Coffee □Sugar
□Salt □Other

CHIEF COMPLAINT _____ HOW LONG_____
CURRENT THERAPIES _____

GENERAL

□ Fever □Wake up easily □Poor appetite □Bleed / Bruise easily
□ Chills □Sudden energy drop at □Heavy appetite □Sweat easily
□Night sweats □Fatigue □Thirsty □Peculiar taste / smell
□Difficulty falling asleep □Tremors □Allergies

SKIN AND HAIR

□Rashes □Itching □Eczema □Hives
□Hair loss □Acne □Psoriasis □Other

HEAD,EYES,EARS,NOSE AND THROAT

□Dizziness getting up □Headaches □Dry Mouth / Throat □Sinus problems
□Dizziness laying down □Migraines □Nose bleeds □Poor hearing
□Night blindness □Sore eyes □See spots □Recurrent sore throat
□Blurry vision □Ear aches □Grinding teeth □Sores on lips / tongue
□Ringing in ears □Gum problems □Excess saliva □Mucus /Phlegm

CARDIOVASCULAR AND RESPIRATORY

□High / Low blood pressure □Bronchitis □Chest pain □Varicose veins
□irregular heart beat □Cough □Fainting □Cold hand / feet
□Shortness of breath □Asthma □Phlebitis □Swelling hands / feet

GASTROINTESTINAL

□Bowel Movement ___x / day □Odor-very strong □Haemorrhoids □Nausea
□Constipation □Bloody / Black stools □Rectal pain □Vomiting
□Diarrhea _____ or _____ □Laxative use □Pain or cramps □Belching
□Alternating □Gas □Rectal prolapse □Bad breath

GENITO-URINARY

□Frequent urination □Wake up to urinate □Blood in urine □Impotence
□Urgency to urinate □Painful urination □Unable to hold urine □Kidney stones

GYNAECOLOGY

Period (□reg 28 days □irreg) □Breast lumps / swelling □Discharge □Premature births
Duration _____days? □Painfull period □ Birth control Pregnant?□Yes □No
Last period_____ □ Mood changes □Menopause (age?) □Miscarriages
Flow:□Heavy □Med □Light □Clots □Spotting Colour:□Dark □Light □ Med No./ Pregnancies_____ Births_____

MUSCULO-SKELETAL

□Joint Pains □ Muscle pains □ Neck pain □Back pain

NEUROPHYSIOLOGICAL

□Anxiety / fear □Poor memory □ Depression □ Areas of numbness
□Easily stressed □Bad temper □Treated for emotional probems □ Other _____

DR HARRESON CALDWELL _____ Date _____

Note: This form is not a recommendation or prescription and is only used for confirmation of diagnosis