Chestermere Lifepath WELLNESS

WELCOME TO THE

LIFEPATH ACUPUNCTURE CARE

Dr. David He RAc. MD TCMD

DATE: _____2016 Email:_____

FULL NAME: Mr.☐ Ms.☐ Mrs.☐ _____(_____)_____
First name initial last name

ADDRESS: _____

City:_____ Postal Code:_____

Cell: _____--_____ Home:_____---_____ Work:_____--_____

DATE OF BIRTH: M/___D/___ Y/_____ Age____ Referred By:_____

MARITAL STATUS (circle): Single Married Common Law Separated Divorced Widowed

Name of Spouse:_____ No. of Children: Boys____ Girls____

YOUR JOB DESCRIPTION: _____ ☐ Not employed at this time
Check All Appropriate Descriptors (circle): - Full Time job - Part Time job
- Student - Athlete - Housewife/Househusband - Farmer - Retired

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1. Main concerns or health goals:_____
2. What caused your problem? _____
3. When did you first notice your problem? _____
4. Is this a Workers' Compensation Case? (injury at work place)..... No ☐ Yes ☐
5. Is this a Personal Injury Case? (i.e., injury from a motor vehicle accident)..... No ☐ Yes ☐
6. Is this an athletic injury? (injury from a sports activity).....No ☐ Yes ☐

HEALTH CARE TREATMENT HISTORY

1. Name of Your Family Physician: Dr. _____
2. Last Medical Visit (month/year):_____ For _____
3. Last Physical Exam (month/year):_____Recent Medical X-rays? NO ☐ ☐☐☐ ☐
4. Number of Drug Prescriptions in last 12 months: 1 ☐ 2-3 ☐ 4-5 ☐ more ☐ none ☐
5. Previous Acupuncture Care: No ☐ Yes ☐ ➪ Date (month/year)_____
   Name of Acupuncturist Dr._____ Chiropractic X-rays: Yes ☐ No ☐
6. Previous Physiotherapy Care: No ☐ Yes ☐ ➪ Date (month/year)_____
   Name of Physio Clinic: ._____
7. Previous Massage therapy: No ☐ Yes ☐ ➪ Date(month/year)_____
   Name of Therapist: Dr._____
8. Previous stay in hospital? No ☐ Yes ☐ ➪ Date (month/year)_____
   Reason._____ X-rays at the Hospital: No ☐ Yes ☐

……..continued on other

LIFEPATH WELLNESS CENTRE - ACUPUNCTURE CARE

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General Health History and Clinical Conditions

Questions and Answer

CHEST:

_____ Chest pain

_____ Pain around ribs

_____ Breast pain

_____ Difficulty swallowing

_____ Chronic cough

_____ Wheezing/Asthma

_____ Bronchodilator

HEART/BLOOD:

_____ Irregular heartbeat

_____ High blood pressure

_____ High blood cholesterol

ABDOMEN/DIGESTION:

_____ **Gas** (stomach)

_____ Constipation

_____ Diarrhea

_____ Hemorrhoid pain

_____ Colon Trouble

_____ Distension Abdomen

_____ Excessive hunger

GENITO-URINARY:

_____ Urinary frequency

_____ per night

_____ Bladder problems

_____ Painful urination

_____ Prostate pain/swelling

EYES, EARS, NOSE, &THROAT:

_____ Hay fever reaction

_____ Sinus infection

_____ Nasal breathing problem

_____ Ringing in ears

_____ Sore throat

_____ Enlarged thyroid

_____ Eye pain

Do you have a clinical condition NOT listed above? Please list it below:

1._____

2._____

3._____