Massage Addict

Acupuncture

Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with an acupuncture treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name _____ Email _____

We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone _____ Cell Phone _____ Work Phone _____

Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Date of Birth (MM-DD-YY) _____ Age _____ Occupation _____

How did you hear about us? _____

Doctor's Name _____ Phone _____ Last Check-Up Date _____

Have you had an acupuncture treatment before? ☐ Yes ☐ No If yes, approximate date of last acupuncture treatment _____

Do you see other healthcare practitioners? _____

Current Medications _____

Previous Major Illnesses/Operations (include dates) _____

Allergies/Hypersensitivities _____

Major Accidents (include dates) _____

Other Serious Medical Conditions _____

What brings you in today?

_____

_____

_____

_____

_____

_____

Please check 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

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

Muscle and Joint
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Pain in shoulder
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Arthritis
- ☐ Foot trouble

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

Genitourinary System
- ☐ Frequent/painful urination
- ☐ Blood in urine/stool
- ☐ Mucus in stool
- ☐ Kidney infection/kidney stone
- ☐ Bladder infection
- ☐ Inability to control urine

Ears, Eyes, Nose, Throat
- ☐ Hearing loss
- ☐ Vision problems
- ☐ Glaucoma
- ☐ Ringing in ear(s)
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Hay fever
- ☐ Asthma
- ☐ Dental decay
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

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

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

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

Have you had any of the following?

- ☐ Appendicitis
- ☐ Malaria
- ☐ Chicken pox
- ☐ Alcoholism
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Venereal infection
- ☐ Cold sores
- ☐ Whooping cough
- ☐ Cancer
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Anemia
- ☐ Heart disease
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Measles
- ☐ Goiter
- ☐ Eczema
- ☐ Mental illness
- ☐ Mumps
- ☐ Influenza
- ☐ Gout
- ☐ Polio
- ☐ Pleurisy
- ☐ Pneumatic fever
- ☐ Rubella
- ☐ Parkinson's
- ☐ HIV/AIDS

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the Acupuncturist can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and acupuncture treatment at Massage Addict.
- I authorize Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massage Addict clinic if I relocate or a new Massage Addict clinic opens closer to my household.

Signature _____ Today's Date _____

Updates to your health history are required every 6 months. A new health history form must be filled out every year.

Changes ☐ Yes ☐ No

Comments _____ Signature_____

Changes ☐ Yes ☐ No

Comments _____ Signature_____