The Best of Chinese Medicine

Consultation

Tel: 416-466-2988
379 Danforth Ave, 2nd Floor
Toronto Ontario M4K 1N8
www.bestofchinesemedicine.com

Patient's Name _____ Date _____

REASON FOR VISIT_____

_____

_____

How long?_____ How often?_____

Is there any other health problem that that concerns you besides your major complaint even if you never considered an acupuncturist could help? For example, do you have any sinus problems, hormone problems, asthma, diabetes, digestive troubles, arthritis, fatigue, mood swings, troubles with sleep or any other problems at all that you wish you could get rid of?

_____

_____

What type of treatment are you looking for? Symptom Relief or Permanent/Long Term Relief? _____

Since the time you first had any of these problems, what, if anything, have you tried? _____

_____

How do your health problems effect your job performance? Explain: _____

_____

What hobbies or interests do you have outside of work? _____

_____

Do you have:	1. Trouble falling asleep?	[ ] Yes	[ ] No
	2. Not rested when waking?	[ ] Yes	[ ] No
	3. Frequent wakening during the night?	[ ] Yes	[ ] No
	4. Waking and not being able to fall back asleep?	[ ] Yes	[ ] No
	5. A bowel movement at least once every day?	[ ] Yes	[ ] No
	6. A good appetite and desire to eat?	[ ] Yes	[ ] No
	7. Bloating or digestive problems?	[ ] Yes	[ ] No
	8. Physically active at least 3 times/week?	[ ] Yes	[ ] No
	9. Often catching cold or feeling under the weather?	[ ] Yes	[ ] No
	10. Lack of motivation and/or depression?	[ ] Yes	[ ] No

Other Comments or Concerns Regarding Your Health (medications, past injuries, concerns etc):

_____

_____