POLO
HEALTH + LONGEVITY CENTRE

Confidential Acupuncture Medical History Form

To assist in providing you with the best possible care, please fill in this form as accurately as you can. All of the information will be kept confidential in your patient file.

Today's Date: _____/____/_____
Month / Day / Year

Name: _____/_____/_____
Last Name First Name Middle Initial

Address: _____/_____/_____/_____
Apt#, Street City Province Postal code

Phone: (home)_____ Occupation: _____

Phone: (work)_____ Birth Date:_____/_____/_____(mm/dd/yy)

Phone: (cell) _____

E-mail: _____

Emergency contact name and telephone number: _____

What concerns brought you into the clinic today: _____

What are your present symptoms: _____

_____

Have you ever been treated with Traditional Chinese Medicine?
o Yes: When: _____o No

Are you currently utilizing any other forms of health care?
o Yes:_____o No

Are you currently taking any prescription or non-prescription drugs?
o Yes:_____o No

Are you currently taking vitamins, minerals or herbs?
o Yes: _____o No

Do you use the following? If so, how often?

Cigarettes:_____ Alcohol:_____
Drugs: _____ Coffee: _____

How do you rate your energy level: /10 (10 being high and 0 low)

How do you rate your average stress level? (please circle one)

None Slight Moderate Severe

Is this normal for you? ○Yes ○No

Please list any physical activity (what type / how often):

_____

_____

Have you ever been hospitalized and /or treated for any serious condition or surgeries?

○Yes ○No

If yes, briefly explain for what condition or reason you were hospitalized and the year in which you were hospitalized: _____

Do you have any of the following conditions or symptoms? (please check all that apply)

	Past	Present	Comments
High/Low Blood Pressure	○	○	_____
Stroke	○	○	_____
Heart Condition	○	○	_____
Diabetes	○	○	_____
Circulation Problems	○	○	_____
Deep Vein Thrombosis	○	○	_____
Varicose Veins	○	○	_____
Pregnancy	○	○	_____
Miscarriage	○	○	_____
Abdominal Pains	○	○	_____
Digestive disorders	○	○	_____
Headaches	○	○	_____
Migraines	○	○	_____
Sleep Disorder	○	○	_____
Skin Problems	○	○	_____
Tumors / Cysts	○	○	_____

STI	o	o	_____
Anemia	o	o	_____
Depression	o	o	_____
Allergies	o	o	_____
Asthma	o	o	_____
Infectious Diseases	o	o	_____

Head and Neck
o Dizziness
o Fainting
o Neck Stiffness
o Enlarged Lymph Glands
o Headaches / Migraines
o Other _____

Eyes
o Blurred vision
o Spots / Floaters
o Eye Pain
o Dry Eyes
o Poor Night Vision
o Red / burning or itchy
o Other _____

Ears
o Recurring Infections
o Earaches
o Ringing in ears
o Wax Buildup
o Reduced Hearing
o Other _____

Nose and Throat
o Bleeding Gums
o Sinus infections
o Hay Fever / Allergies
o Recurring Sore Throat
o Swollen Glands
o Hard to Swallow
o Bitter Taste in Mouth
o Canker / Mouth Sores
o Nose Bleeds
o Dry Mouth
o Frequent Thirst

Muscle and Joints
o Joint Pain
oBody Aches or Stiffness
o Muscle Weakness
o Numbness or Tingling
o Backache or Knee Pain
o Other _____

Respiratory
o Wheezing / Asthma
o Difficulty Breathing
o Chronic cough
o Coughing Phlegm
o Coughing Blood
o Frequent Colds
o Other _____

Genital / Urinary
o Pain/Itching of Genitalia
o Genital Lesions/discharge
o Painful Urination
o Frequent Urination
o Urgent Urination
o Urinary Incontinence
o Excessive Urination
o Scanty Urination
o Blood in the Urine
o Wake up to Urinate
o Bedwetting
o Kidney Stones
o Increased Libido
o Decreased Libido
o Other _____

Cardio Vascular
o Heart Palpitations
o Rapid Heartbeat
o Chest Pain or Tightness
o Irregular Heartbeat
o Poor Circulation
o Swollen Ankles
o Edema
o Other _____

General
o Cold Hands or Feet
o Nose Cold
o Aversion to Heat
o Aversion to Cold
o Chills
o Recent Weight Changes
o Fatigue
o Poor memory

Skin
o Hives
o Rashes
o Eczema
o Psoriasis
o Acne
o Itchiness
o Dryness
o Mole or lump changes
o Spontaneous Sweats
o Hot Flushes / Fever
o Bruise Easily
o Fine Hair / Falling Out
o Nails Break Easily
o Other _____

Gastrointestinal
o Nausea
o Vomiting
o Acid Reflux / Heartburn
o Gas
o Bloating
o Abdominal Pains or cramping
o Frequent Hiccups

○ Bad Breath
○ Poor Appetite
○ Ravenous Appetite
○ Hunger with no desire to eat
○ Loose or Soft Stools
○ Constipation
○ Alternate Loose /Constipation
○ Laxative Use
○ Black Stools
○ Blood in Stools
○ Mucous in Stools
○ Itchiness or Pain in Anus
○ Burning Anus
○ Rectal Pain
○ Anal Fissures
○ Hemorrhoids
○ Other _____

Sleep
○ Restful
○ Light
○ Hard to fall asleep
○ Wake up easily / early
○ Dream Disturbed
○ Nightmares
○ Heavy Sleep
○ Night Sweats
○ Hours of Sleep/night ___
○ Other _____

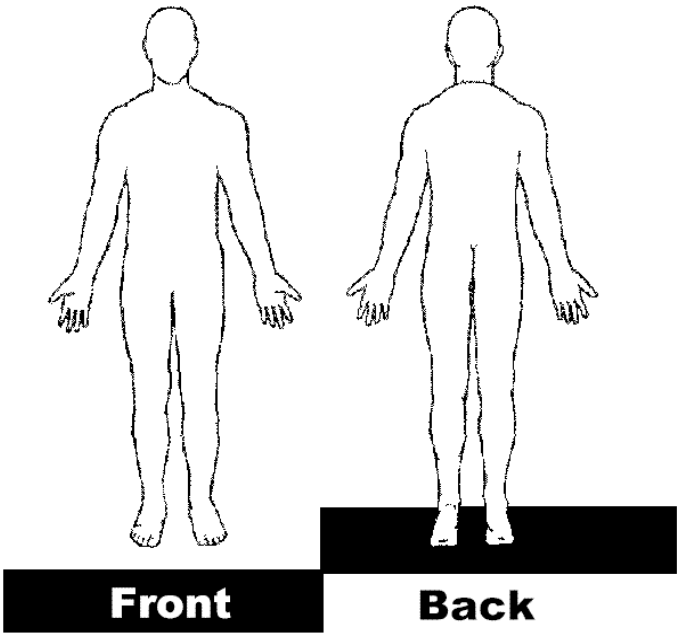
Emotions
○ Relaxed & Calm
○ Sad
○ Fearful
○ Depressed
○ Angry / Frustrated
○ Irritated easily
○ Anxious
○ Stressed
○ Overthinking / Worry
○ Forgetful
○ Manic
○ Impatient
○ Other _____

Do any of the following apply to you:

Haemophiliac	○Yes	○No	Epilepsy	○Yes	○No
Wear a pacemaker	○Yes	○No	Are you a vegetarian?	○Yes	○No
Have a serious heart or lung condition	○Yes	○No	Do you have surgeries scheduled?	○Yes	○No
On anticoagulant ?	○Yes	○No	Are you pregnant or is there a chance you may be pregnant?	○Yes	○No

Do you have Chronic or Acute injuries? ○Yes:_____ ○No

Are you currently experiencing pain? ○Yes: _____ ○No



Please shade and code areas to indicate location of pain or discomfort.

P – Pins & Needles

N – Numbness

S – Spasm

T – Tenderness

A – Aches

R – Radiating

B – Burning

X - Stabbing

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____

_____

What aggravates the pain? _____

_____

Menstruation History:
How old were you when your period first started? age: _____

Date last menstruation started: _____

Usual cycle length (i.e. 28): _____
Is your cycle: Regular / Irregular (Early or Late)

Usual number of bleeding days: _____
Is your flow: Light / Moderate / Heavy
Blood colour: Fresh Red, Scarlet Red, Dark Red, Pink, Purple, Brown, Black
Blood consistency: Watery-thin / Thick / Average

Does your flow have clots? Yes / No

If yes, at what point during the flow: Start / Middle / End

Size of clots: Small / Moderate/ Large

Do you experience any menstrual pain? Yes / No

If yes, at what point during the cycle: Before Flow / During / After

If during the cycle, what days? _____

If yes, what type of pain: Cramping / Stabbing / Heavy / Dull / On and off

What relieves the pain? Pressure / Heat / Cold _____

Do you have nipple sensitivity or discharge? Yes / No

Do you have any PMS symptoms?

Bloating, Bowel Movement changes, Cramps, Mood changes, Acne, Breast tenderness, Headache, Nausea, Fatigue, Sleep disturbances

Any others? _____

Any increase or decrease in energy around menses? Increase / Decrease

If yes, is it: Before / During / After

Any spotting between cycles? Yes / No

If yes, when? Before / Middle / After

<u>General History:</u>

Any vaginal secretions (discharge)? Yes / No

If yes, what colour: White / Yellow / Green / Pink / Red

Consistency: Watery / Thick / Sticky

Odour: None / Unpleasant

Date of last physical examination with your General Practitioner (MD): _____

Have you ever had:

○ Abnormal pap smear; details_____ ○ Cervical operations; when? _____

○Yeast infections; last one _____ ○ Bladder infections (Urinary Tract Infections)

○Chlamydia ○PID (Pelvic Inflammatory Disease)

Have you ever been diagnosed with infections/sexually transmitted disease? Yes / No
If yes, when _____ and how it was treated_____

Have you ever been diagnosed with:

- ○ Uterine fibroids
- ○ Polyps
- ○ Pelvic Adhesions
- ○ Prolapsed bladder
- ○ Prostate Issues
- ○ Endometriosis
- ○ PCOS
- ○ Prolapsed uterus
- ○ Pelvic abnormalities
- ○ Other _____

1. What are some expectations that you have of our treatments and of me as your health care provider?

2. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (rate from 0 to 10, 10 being 100% committed)

3. How do your current lifestyle choices support your health?

4. How do your current lifestyle choices impede in the achievement of your good health?

5. What do you do for fun?

Patient Advisory

During or after an acupuncture treatment certain adverse side effects, although rare, may result.

These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. No guarantees concerning its use and effects are given and you are free to refuse treatment at any time.

By signing below, I do hereby voluntarily consent to be treated with acupuncture by Aleksandra Wroblewska.

Name (please print): _____

Signature_____Date_____

Fee Schedule

ACUPUNCTURE

- Initial Consultation with Treatment: $125.00 (1 hour)
- Subsequent Treatments: $95 (45 minutes)
- 3 Session Package: $256.50 (10% savings)
- 5 Session Package: $403.75 (15% savings)
- 10 Session Package: $760.00 (20% savings)

Missed Appointment Fee:

PATIENTS WILL BE CHARGED THE FULL FEE FOR ANY MISSED APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME.

Payment is due when services rendered and may be paid by cash, credit card, or debit. If requested, receipts will be issued upon payment. Patients with extended health policies that cover acupuncture treatments must collect from their insurance company after payment.

Having read the statement above I fully understand and accept this fee schedule.

PATIENT'S SIGNATURE: _____

Date: _____

Guardian Signature (if patient is under 18 or unable to sign)_____