REJUVENATION
HEALTH SERVICES

ACUPUNCTURE HEALTH HISTORY

Patient Name: _____ Age: _____

Height: _____ Weight: _____

What is your primary concern/complaint: _____

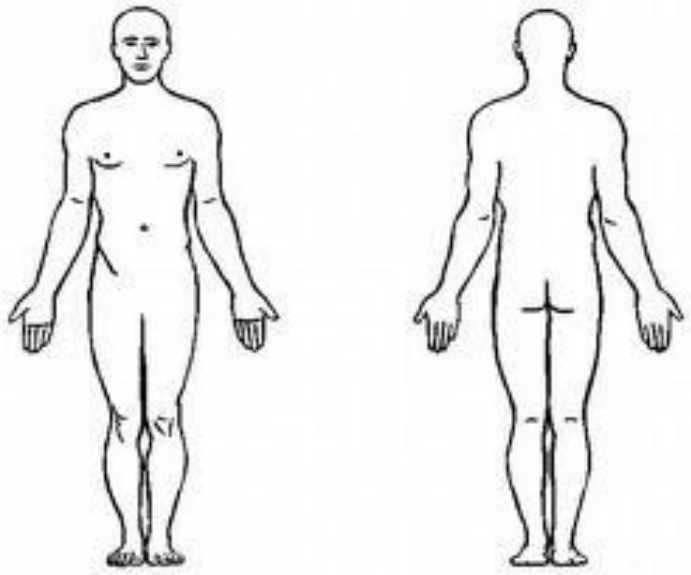
_____

_____

Check off any of the conditions listed below that currently affects you or that you have experienced in the last 5 years:

__ Depression
__ Anxiety/Nervousness
__ Stress/Tension
__ Fatigue
__Fainting
__ Headache
__ Migraine
__ Dry Eyes
__ Eye Pain
__ Low Jaw
__ Blurred Vision
__Hearing Loss
__ Ears Ringing
__ Sinus Problems
__ High/Low Blood Pressure
_____
__ Vertigo/Dizziness
__Anemia
__ Bruise Easily
__ Diabetes
__ Insomnia
__ Memory Problems
__ Menopause
__ Bell's Palsy (Facial Paralysis)
__ Night Sweats/Hot Flashes
__ Frequent Cold/Flu
__ Chill/Fever
__ Amenorrhea
__ Dysmenorrhea
__Infertility

Please indicate for the therapist on the diagram where you are experiencing your pain or concern.



2051 Leger Road NW (Terwillegar Recreation Centre), Edmonton AB T6R 0R9 | Phone: 780.431.9623 | Fax: 780.431.9624
203, 16028 – 100A Avenue NW | Edmonton AB T5P 0M1 | Phone: 587.524.9623 | Fax: 587.524.9624
#102, 2704-17 St NW I Edmonton AB T6T 0X1 I Phone: 780.465.9940 I Fax: 780.465.9944
info@rejuvenationhealth.ca | www.rejuvenationhealth.ca

Continued Acupuncture Health History

__ Sciatica
__ Osteoarthritis
__ Arthritis
__ Low Back Pain
__ Knee Pain
__ Heel Pain
__ Fibromyalgia
__ Stroke
__ Skin Problems

__ Shortness of Breath
__ Tight Chest
__ Palpitation
__ Heart Attack
__ Poor Appetite
__ Excessive Gas
__ Heartburn
__ Stomach Ache/Pain
__ Digestive Disorder

__ Night Urination
__ Frequent Urination
__ Urinary Incontinence
__ Diarrhea
__ Irritable Bowel Syndrome
__ Hemorrhoid

_____

_____

Current Medications:

__ Laxatives __ Cortisone __ Tranquilizers __Sleeping Pills

__ Pain Relievers __ Hormones __ Antibiotics __ Antacids

Name(s) of Medication: _____

FEMALE CLIENTS:

__ Pregnant ____ # of Pregnancies __ Infertility

Menarche (Age): _____ Menstrual Phase ___ days Menstrual Cycle ___ days Menopause (Age): _____

MALE CLIENTS:

__ Impotence __ Premature Ejaculation __ Prostatitis

__ Spermatorrhea __ Nocturnal Emission

Surgery History: _____

Injury History: _____

Insurance Covered? Y/N Insurance Company: _____

The above information is accurate and true to the best of my knowledge.

Signature: _____ Date: _____

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