BALANCED BODY ACUPUNCTURE

Date	Phone #
Patient Name	Email
Date of Birth	Address
Height City	
Physician	Postal Code
Dr Phone #	Occupation
Marital Status	Employer
# of Children	# of hours worked per week
Ages of Children	Do you enjoy your work?
How did you hear about me?	

Anytime you see a list of options, please circle all that apply to you

Main Reason for today's visit?

What makes it better or worse?

When did this start?

Is this work related?

Related to an automobile accident? And ICBC claim #

Please list any other concerns you would like to address

Goals for care: Relief Correction Maintenance Prevention Wellness

Pain: Persistent _____ Lingering _____ How often do you feel it? _____
Level Today 1 2 3 4 5 6 7 8 9 10
Location(s)

Worse or Better with and when

Pain relieved by: Heat Cold Pressure Massage

General Body Aches?

Frequency and location of headaches

Body Temperature Hot or Cold Location:

Time of Day you feel hot or cold?

Energy Level 1 2 3 4 5 6 7 8 9 10 Notes

Sleep: How many hours per night? Regular times?

Do you feel rested in the morning?

Trouble falling asleep or staying asleep?

How well do you sleep? Dreams?

Exercise Frequency, Duration, Activity (usual or current)

Emotions: do you experience:
Insomnia Drowsiness Memory Loss Disorientation Happiness Sadness Worry
Anxiety Fear Frustration Anger Sense of Loss Loneliness Mania Helplessness
Tension Depression Mood Swings PMS Sex Drive: high / low

Appetite: Poor Appetite Belching Gas Acid Reflux Bloating After Meals Constant Hunger
Eating Continuously Sweet Taste in mouth Bitter Taste in Mouth Cravings:
Notes

# of meals per day Quantity: Large Moderate Small
Types of Food Consumed Daily

Please indicate the use and frequency of the following: Yes No & How Much	
Water	Tobacco
Coffee	Recreational Drugs
Milk	Alcohol
Juice	Pop

Thirst: Thirsty Prefer Hot Drinks or Cold Drinks Thirsty but no desire to drink
Not thirsty at all

Bowels: Constipated Loose Stools Diarrhea Diarrhea With Undigested Food Early Morning
Diarrhea Alternates between constipation and Diarrhea
Number of BMs per day _____

Urination: Deep Yellow Clear & Profuse Blood in Urine Difficulty Urinating
Number of times waking up at night to urinate _____
Frequency / Volume _____

Sweating: Spontaneous Night Sweating Profuse Cold Sweating Odor Yellow Stained Sweat
No sweat or very little sweat

Heart: Palpations Arrhythmia Hypertension Hypotension BP Rate: _____

Menstrual: Regularity of Cycle _____ # of Days _____ Colour _____ Excessive Flow Scanty Flow Blood Clotting Cramping Breast Distention PMS: Migraines Depression Irritability Constipation Nausea

Date of last period	Vaginal Discharge?
Birth Control	Are you pregnant?
Are you breastfeeding?	Breast implants?
Pregnancy History:	
Menopausal Related Symptoms:	

Men only: Last Prostate Exam Date: _____ Results: _____ Groin Pain Testicular Pain Painful Urination Difficult Urination Dribbling Urine Incontinence Decreased Libido Increased Libido Premature Ejaculation Nocturnal Emissions Impotence

Other: Ringing in the Ears Dizziness
Medical History: Diseases / Allergies / Major Accidents / Immediate Family

Do you currently have or have you ever had any of the following?
Asthma Allergies Digestive Disorders Ulcers Anemia Thyroid Issues
Kidney Stones Gall Stones Kidney Disease Diabetes Heart Problems
High Blood Pressure Pacemaker Stroke Epilepsy Multiple Sclerosis Fibromyalgia
Arthritis Osteoporosis Emotional Disorder Alcoholism
Drug Problems Tuberculosis HIV AIDs Hepatitis Cancer Hemophilia

Hospitalizations and
Surgeries:

What are you most important health challenges: (list in order)
1)
2)
3)
4)
5)

What have you done to improve your health?
Exercise Meditation Supplements Herbs Cleanse Organic foods Massage
Chiro Naturopathy Homeopathy Acupuncture Physiotherapy Other:
Please list any health practitioners you see regularly:

Current Medication and Supplements:

BALANCED BODY ACUPUNCTURE

Patient Consent Form

Please read this information carefully. If there is anything you do not understand, ask Darcia Dahl.

I hereby request and consent to the performance of acupuncture and other related procedures including needling, moxabustion, cupping, acupressure, guasha, and techniques within the scope of acupuncturists by Darcia Dahl. I have had the opportunity to discuss with Darcia the nature and purpose of acupuncture care and related procedures.

While acupuncture, and other Chinese Medicine treatments have proven to be highly effective in correcting conditions and maintaining overall well-being, I understand that results are not guaranteed nor is Chinese medicine a replacement for Western Medicine including regular check-ups with your physician.

I am informed that acupuncture is a safe method of treatment, but it may have side effects including temporary soreness, numbness or tingling near the needling sites, bruising, minor bleeding, nausea, and drowsiness or even fainting could occur in a very small number of patients. Bruising is a common side effect of cupping and can last up to seven days.

By voluntarily signing below I confirm that I have read and understood the above information, and I consent to having treatments and procedures from Darcia Dahl. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on Darcia Dahl to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand Darcia Dahl may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Date: _____

Print Name: _____

Signature: _____

I acknowledge that if I do not give 24 hours notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

Date: _____

Signature: _____