



Kendra Heck, BSc, RMT, RAc
Suite 300 933 17ave SW, Calgary, Alberta T2T 5R6
(403) 244-9111 www.myfruition.com ou-chi@hotmail.com

Patient Name: _____ Today's Date: (MM/DD/YYYY) _____

Date of Birth: (MM/DD/YYYY) _____ Sex: M / F

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Physician: _____ How did you hear about this office? _____

Emergency Contact: _____ Phone: _____

What type of care are you interested in? :Acute___Preventative___Wellness___

Main Complaint:

History of Complaint:

Are you currently affected by any of the following:

Pregnancy: Due Date _____ Breast-feeding _____ Cold/Flu _____ Infection/Inflammation _____

Does your occupation involve:

Sitting _____ Standing _____ Driving Lifting _____ Mouse/Keyboarding _____ Reading _____

What type of activities/exercise do you do, including frequency and duration?

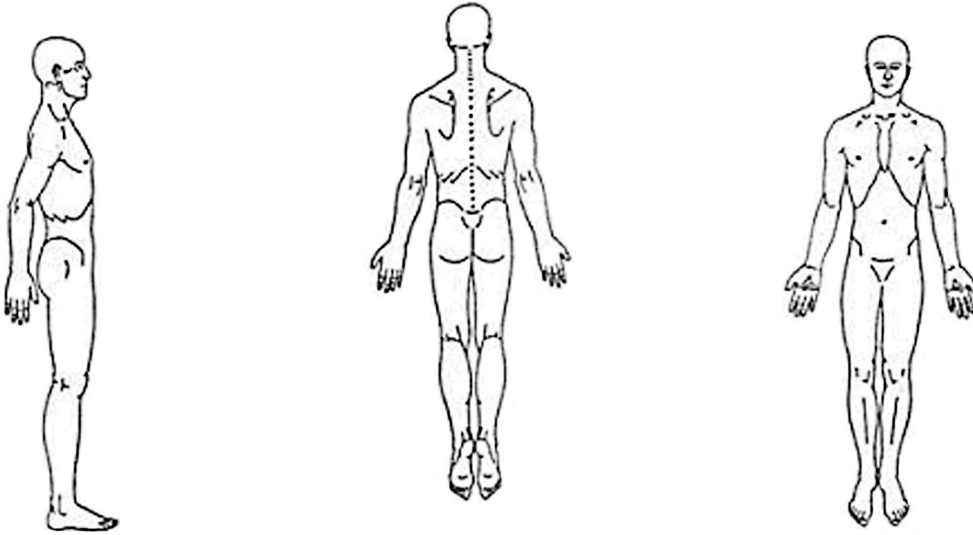
Have you ever/are you currently experiencing any of the following:

AIDS/HIV + _____ Cancer/Tumor _____ Allergies _____ Diabetes _____ Hepatitis _____
Hypertension _____ Bleeding Disorder _____ Heart Disease _____ Seizure Disorder _____

Please list any medications/supplements you are currently taking including frequency and duration:

List any previous major injuries, surgeries or diseases along with dates:

Please indicate any areas you are currently experiencing pain.



Do you experience any numbness? ____ Tingling? ____ Distension? ____
Heaviness? ____ Itching? ____ If so, where? _____

How are your energy levels? _____

How are your stress levels? _____

Your body temperature can be described as: Hot ____ Cold ____ Average ____

Do you experience headaches? ____ How frequently? _____
Where? Temples ____ Forehead ____ Back of head ____ Whole head ____

Do you experience dizziness? ____ Vertigo? ____ How often? _____

Have you experienced any hearing loss? _____ Tinnitus? _____

How is your memory/concentration? _____

How is your vision? _____ Sinus congestion? _____

Do you experience a dry mouth or throat? ____ Canker sores? _____

Do you experience any out of the ordinary sweating? _____
Day ____ Night ____ On slight exertion ____ How frequent? _____

Shortness of breath? ____ Cough? ____ Stifling sensation in chest? ____

Do you have an skin concerns:

Acne ___ Itching ___ Eczema ___ Hives ___ Dry/Cracking ___
Rashes ___ Warts ___ Moles ___ Boils ___ Blisters ___ Other _____

Palpitations? ___ With exertion or at rest? _____ Frequency? _____

How is your sleep? _____

Do you experience nausea? ___ Vomiting? ___ Acid regurgitation? ___

How is your appetite? Good ___ Poor ___ Excessive ___

How is your digestion? Good ___ Poor ___

Do you experience any bloating? (Especially after eating?) _____

Bowel Movements:

Frequency: less then 1 every other day ___ 2 per day _____
1 every other day _____ 3 per day _____
1 per day _____ more than 3 per day _____

Consistency: watery (diarrhea) _____ hard and dry _____
loose _____ painful _____
formed, but soft _____ blood _____
formed _____ mucus _____
hard _____ intestinal gas _____

Urination:

Frequency: infrequent _____ very frequent _____
average _____ incontinent _____
frequent _____ during night (waking) _____

Color: dark yellow _____ clear _____
yellow _____ blood _____
pale yellow _____

Amount: scanty _____ copious _____
average _____ painful _____

Menstruation:

Cycle: How many days on average? _____
Is it regular? _____
Duration? _____

Amount: scanty _____ average _____ copious _____

Color: pale red _____ bright red _____ dark red _____ purple _____

Consistency: thin/watery _____ average _____ thick _____

Menstruation: (Continued)

Clots? _____ If so, how big? _____ PMS? _____

Pain? before _____ during _____ after _____ during ovulation _____

Any other gynecological issue you would like to address? _____

Number of pregnancies? _____ Number of children _____ Number of miscarriages _____

Any other concern you would like to address? _____

Risks and cautions of Acupuncture:

1. Acupuncture may cause minor bruising or soreness around the needling area.
2. Treatments may cause dizziness, fainting, fatigue or a temporary worsening of symptoms.
3. Do not exercise just before or after a treatment.
4. Do not eat a large meal right before or after a treatment. A small snack is appropriate.

Informed Consent:

I, the undersigned, understand that acupuncture and related therapies are given for the purpose of relieving pain and benefiting my health and wellness. I understand that diagnosis and treatment by the acupuncturist does not replace the diagnosis and treatment of a physician or dentist. In accordance with Section 8(1) of Alberta's Acupuncture Regulation, I have consulted with a physician or dentist for my condition prior to receiving acupuncture treatments, or agree to seek consultation before any future acupuncture treatments. I understand that decisions to alter or stop medications are at the discretion of a physician. I understand the risks and benefits of acupuncture as explained to me and consent to receive treatment by an acupuncturist, taking full responsibility for the outcome of the therapy. I attest that all information provided to my therapist is complete and true.

Signature: _____ Date: _____

Note that 24 hours notice is required to avoid billing for cancelled or missed appointments.