Aloe Health

Acupuncture + Traditional Chinese Medicine

File #: _____

Patient Information		
First Name:	Last Name:	Middle Name:
Telephone (Home/Mobile):	Telephone (Business):	Gender:
Address: Apt #:		Date of Birth: (DD/MM/YYYY)
City: Province: Postal Code:		Marital Status:
Occupation:	Email:	
Family Contact Information	First name:	Last name:
Relationship to Patient:	Phone Number:	Mobile Number:
Emergency Contact information (If different individual from above)	First name:	Last Name:
Relationship to Patient:	Phone Number:	Mobile Number:
Family Doctor Name:		
Clinic Address:		
Clinic Phone:	Clinic Email:	

Past Medical History

Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.

Ongoing Health Conditions / Allergies/Drug Reactions / Risk Factors/Long Term Treatment

Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.

Please circle any conditions you are experiencing (past and present):

General Symptoms	***Cardiovascular***	***Ear Eye Nose Throat***	***Gastrointestinal***
☐ Dizziness/light headiness	☐ High/low blood pressure	☐ Hearing loss	☐ Distress from greasy food
☐ Fever	☐ Previous stroke or TIA	☐ Vision problems	☐ Poor appetite
☐ Chills	☐ High cholesterol	☐ Glaucoma	☐ Excessive hunger / thirst
☐ Sweat	☐ Swelling of ankles	☐ Ringing in ear(s)	☐ Belching or gas
☐ Memory loss	☐ Poor circulation	☐ Crossed eyes	☐ Nausea
☐ Headaches / migraines	☐ Stroke/heart attack	☐ Eye pain	☐ Vomiting
☐ Fainting	☐ Irregular heart beat	☐ Deafness	☐ Burning in stomach
☐ Stress / depression	☐ Shortness of breath	☐ Earache	☐ Pain over stomach
☐ Discoordination	☐ Pain over heart	☐ Ear discharge	☐ Constipation / diarrhoea
☐ Nervousness		☐ Nose bleeds	☐ Colon trouble
☐ Recent weight loss/gain	***Muscle and Joint***	☐ Nasal obstruction	☐ Liver trouble / hepatitis
☐ Numb/pain in arms/legs	☐ Stiff neck	☐ Sore throat	☐ Gall bladder
	☐ Back ache	☐ Hoarseness	☐ Ulcers
For Women	☐ Swollen joints	☐ Hay fever	☐ Colitis
☐ Cramps / backache	☐ Painful tailbone	☐ Asthma	☐ Haemorrhoids
☐ Previous miscarriage	☐ Pain in shoulder	☐ Dental decay	☐ Hypoglycaemia
☐ Irregular cycle	☐ Hernia	☐ Gum trouble	☐ Hiatal hernia
☐ Vaginal discharge	☐ Spinal curvature	☐ Frequent colds	☐ Metallic taste
☐ Lumps in breast	☐ Faulty posture	☐ Enlarged thyroid	
☐ Hot flashes	☐ Arthritis	☐ Tonsillitis	***Skin***
☐ Pregnant	☐ Foot trouble	☐ Sinus infection	☐ Dryness
☐ Painful menstruation		☐ Nasal drainage	☐ Itching
☐ Excessive flow	**Genitourinary System**	☐ Enlarged glands	☐ Bruise easily
☐ Menopausal symptoms	☐ Frequent/painful urination		☐ Skin conditions / rashes
☐ Hysterectomy	☐ Blood in urine / stool	***Respiratory***	☐ Boils
	☐ Mucus in stool	☐ Wheezing	☐ Varicose veins
	☐ Kidney infection / stone	☐ Chronic cough	☐ Sensitive skin
	☐ Bladder infection	☐ Spitting up phlegm	☐ Hives or allergy
	☐ Inability to control urine	☐ Chest pain	
		☐ Difficulty breathing	

Please identify if you've had any of the following:

☐ Appendicitis	☐ Malaria	☐ Chicken pox	☐ Alcoholism	☐ Osteoporosis
☐ Diabetes	☐ Venereal infection	☐ Cold sores	☐ Whooping cough	☐ Cancer
☐ Epilepsy	☐ Multiple sclerosis	☐ Anemia	☐ Heart disease	☐ Tuberculosis
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Eczema	☐ Mental illness
☐ Mumps	☐ Influenza	☐ Gout	☐ Polio	☐ Pleurisy
☐ Pneumatic fever	☐ Arthritis	☐ Rubella	☐ Parkinson's	☐ HIV / AIDS

Signature of Patient/SDM: _____ **Date:** _____

Relationship of SDM (substitute decision maker) to patient: _____