木火土金水 **Birmingham Traditional Acupuncture Centre** - Steve Lowe

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Date:

CONFIDENTIAL - Patient Questionnaire

All information you give is confidential and will help in planning appropriate treatment.

Full Name: _____ **Date of Birth:** ___/___/___

Do you have any of the following? *(please circle any that apply)*

Asthma / Diabetes / Epilepsy / High Blood Pressure / Heart Disease / Disease of the Heart Valves / Pacemaker/ Hepatitis / HIV / AIDS/ Lymphoedema

Occupation: _____

Marital Status / Partner: _____ Number and ages of children (if any): _____

MAIN COMPLAINT *(What are you seeking acupuncture treatment for?)*

1) _____

How long have you had the problem? _____

OTHER COMPLAINTS

2) _____

3) _____

Main complaint *(Further details - how it affects you on a day to day basis?)*

_____

_____

_____

_____

MEDICAL HISTORY *(Conditions or operations, with age at time of diagnosis/surgery)*

_____

_____

_____

MEDICATION: *(Please list any medication/supplements you are currently taking)*

Do you smoke? Yes *(__ per day)* / **No** / *Gave up __ weeks/months/years ago*

FAMILY MEDICAL HISTORY:

SLEEP PATTERNS: *(e.g. Do you fall asleep easily/wake in the night/dream regularly?)*

ENERGY LEVELS: *(e.g. Are they higher/lower at particular times of the day?)*

DIET: *(e.g. How often do you eat, particular likes/dislikes?)*

Allergies:

FLUID INTAKE: *(What do you drink and how much? including alcohol)*

OTHER CONCERNS: *Do you have any concerns about the regularity or type of bowel movements, or problems with your waterworks, or (if applicable) your periods?*