3885 Duke of York Blvd., Suite C211, Mississauga, ON L5B0E4 T: (905)276-6800 F: (905)276-6802 www.NaturaWellnessClinic.com

DATE OF FIRST VISIT: ____________________

ACUPUNCTURE - NEW PATIENT INFORMATION FORM

NAME: _______________________________ D.O.B. (DD-MM-YY): ____-____-____ PLACE OF BIRTH: ____________

ADDRESS: __________________________________ CITY: ___________________ POSTAL CODE: ______________

TEL: (Home) _______________________ (Work) _________________________ (Cell) __________________________

MAY WE CONTACT YOU BY PHONE/E-MAIL FOR UPDATES, EDUCATIONAL NEWS OR CLINIC PROMOTIONS? Y / N

E-MAIL ADDRESS: ____

Reason for visit today:

Are you on medication? (If so, for what condition) (Including vitamins and herbs)

Surgery (date and details):

Any major traumas (auto, fall, etc.)?

Significant Illnesses

- ☐ Cancer
- ☐ Diabetes
- ☐ HIV
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Muscle spasms
- ☐ Seizures
- ☐ History of fainting
- ☐ Heart disease
- ☐ Allergies:____
- ☐ Other: ____

Habits and frequency:

- ☐ Cigarettes: ____________
- ☐ Drugs: _______________
- ☐ Cravings: _____________
- ☐ Caffeine: ____________
- ☐ Salt: _______________
- ☐ Other: _______________
- ☐ Alcohol: ______________
- ☐ Sugar: _______________

Please check of any of these symptoms apply to you:

Skin and Hair

- ☐ Rashes
- ☐ Pimples
- ☐ Ulcerations
- ☐ Eczema
- ☐ Hives
- ☐ Dandruff
- ☐ Itching
- ☐ Loss of hair
- ☐ Easy bruising
- ☐ Excessive sweating
- ☐ Night sweating
- ☐ No sweating
- ☐ Dry skin
- ☐ Recent moles
- ☐ Other: _______________

Head and Neck

- ☐ Headache
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Concussions
- ☐ Swollen glands
- ☐ Stiff neck
- ☐ Other: _______________

Ears

- ☐ Ringing
- ☐ Earache
- ☐ Poor hearing
- ☐ Vertigo
- ☐ Other: ________________

Eyes

- ☐ Glasses/contacts
- ☐ Blurry vision
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor night vision
- ☐ Cataracts
- ☐ Spots/floaters
- ☐ Other: ________________
- ☐

Nose, Throat, Mouth

- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Dry nose
- ☐ Difficulty swallowing
- ☐ Mouth/ tongue ulcers
- ☐ Frequent sore throat
- ☐ Excessive thirst
- ☐ Dry mouth
- ☐ Jaw clicks
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Facial pain
- ☐ Other: ________________

Respiratory

- ☐ Chronic cough
- ☐ Coughing blood
- ☐ Production of phlegm
- ☐ Asthma
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Difficulty breathing
- ☐ Difficulty breathing lying down
- ☐ Other: _________________

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain/ tightness
- ☐ Palpitations
- ☐ Irregular heartbeat
- ☐ Cold hands/feet/poor circulation
- ☐ Swollen hands/feet
- ☐ Blood clots
- ☐ Anemia
- ☐ Sciatica
- ☐ Bruise easily________
- ☐ Tremors
- ☐ Chills/fever
- ☐ Other: ________________

Gastrointestinal

- ☐ Nausea
- ☐ Stomach pain
- ☐ Indigestion
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Hiccups
- ☐ Bad breath
- ☐ Acid regurgitation
- ☐ Bloating
- ☐ Laxative use
- ☐ Mucous in stool
- ☐ Blood in stool
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Weight loss/gain
- ☐ Peculiar tastes smells bothersome
- ☐ Other: __________________

Urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Uncontrolled bladder
- ☐ Incomplete urination
- ☐ Bedwetting
- ☐ Wake to urinate
- ☐ Cloudy urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Other: ______________

Genito

- ☐ Increased/decreased libido
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Pain/itching of genitals
- ☐ Other: ________________

Obstetrics and Gynecology

Number of pregnancies: ____

Number of births: ____

Number of miscarriages: ____

Abortions: ___

Age at first menses: ____

Length of cycle: ____

Of days bleeding: ___

Dull red, dark red, purple, brown in color? (Circle)

- ☐ Clots
- ☐ Irregular period
- ☐ Light/heavy
- ☐ PMS- before, during, after
- ☐ Vaginal discharge
- ☐ Hormone imbalance
- ☐ Breast lumps
- ☐ Menstrual cramps

Other menstrual related pain:

____

Changes in body/psyche prior to or during menstruation/ PMS symptoms:

____

Sleep

- ☐ Poor sleep
- ☐ Insomnia
- ☐ Unrested upon waking
- ☐ Dreaming
- ☐ Dream disturbed
- ☐ Night sweats
- ☐ Other: ______________

Musculoskeletal

- ☐ Joint pain/disorder
- ☐ Localized weakness
- ☐ Limited range of motion
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Shoulder pain
- ☐ Lower back pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Wrist/hand pain
- ☐ Other:

____

Neuropsychogical

- ☐ Irritability
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Poor short term memory
- ☐ Poor long term memory
- ☐ Bad temper
- ☐ Sudden energy drop (time of day______)
- ☐ Stressed out
- ☐ Poor coordination
- ☐ Poor balance
- ☐ Fatigue
- ☐ Areas of numbness
- ☐ Seizures
- ☐ Tremors

Have you ever been treated for emotional problems?

____

Have you ever considered or attempted suicide?

____

Other neurological or psychological problems

____

Authorization for Treatment

I understand the nature of the treatments provided by Jessica Vella and agree to work with her to attain my optimum health. I will provide as much background information as necessary and I realize that this information is confidential and is strictly used for the benefit of my treatment.

Signature: ______________________________ Date: ____________________