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| --- | --- |
|  | Date: |
| Title:  Surname: First Name: | |
| D.O.B: | Age: |
| Address: | Phone (Home) |
|  | Phone (Mobile) |
|  | Phone (Work) |
| Postcode: | Occupation |
| Email: | Have you had acupuncture before:  If so when: |
| GP:  Permission to contact your GP if necessary: YES/ NO   |  | | --- | |  | | GP Contact details: |
| How did you hear about Chameleon acupuncture & wellness: | |

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| What is your primary (main) complaint: |
| What is your secondary complaint: (if any) |
| Western medical diagnosis (if any): |
| Other medical treatments received: |
| Please list any prescription medications and/or over the counter drugs you are currently taking |
| Please list any herbal medicines and/or supplements you are taking: |
| Please list any allergies you may have (food, drugs, herbal, environmental) if any: |

Do you use any of the following (if so how much/often)

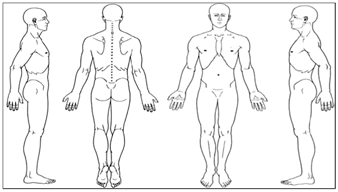
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cigarettes: | Alcohol: | Tea/Coffee: | Fizzy Drinks | Drugs |

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| Weekly exercise |

Please incicate with a **‘P’** (past) **‘C’** (Current) **‘F’** (Family) if any of the conditions below apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Heart conditions/angina |  | Stroke |  | High Blood pressure |  | Spinal or injury |
|  | Diabetes |  | Deep vein thrombosis |  | Neurological |  | Hepatitis |
|  | Respiratory condition |  | Kidney disorder |  | Cancer |  | Headaches/migraines |
|  | Blood borne viruses e.g. Hepatitis B/C or HIV |  | Sprain/Strain/Fracture |  | Osteoporosis |  | Contagious illness |
|  | Jaw pain/Dental work |  | Arthritis |  | Dizziness/fainting |  | Pacemaker |
|  | Skin Condition |  | Digestive problems |  | Hemophilia |  | Ear infection/Tinnitus |
|  | Lung Condition |  | Epilepsy/Seizures |  | Low Blood Pressure |  | Vision issues (blurred/ floaters) |
| Are you pregnant (if yes how many months): Y/N  Are you trying to conceive: Y/N | | | | | | | |
|  | | | | | | | |
| On a scale of 1-10, how would you rate your daily energy level (10 being best)? **\_\_\_\_ / 10** | | | | | | | |
| Do you have trouble falling asleep? **Y / N** | | | | | | | |
| Do you wake and have difficulty falling asleep? **Y / N** | | | | | | | |
| Are you a light sleeper? **Y / N** | | | | | | | |
| How many hours per night? **\_\_\_\_\_** | | | | | | | |
| Do you have vivid dreams? **Y / N** | | | | | | | |
| If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.): | | | | | | | |

On the diagram below, indicate where you have your pain or symptoms



*Sensations/pain characteristics (tick if applicable):*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Sharp* |  | *Moving* |  | *Dull* |  |
| *Burning* |  | *Tingling* |  | *Stabbing* |  |
| *Shooting* |  | *Thorbbing* |  | *Numbness* |  |

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| On a scale of 1-10 (10 being worst) how would you rate your pain level? \_\_\_\_ / 10 |
| What relieves the pain (ice, Rest, Activity, Massage, heat etc) |
| What aggravates the pain (weather, heat, cold, rest, activity)? |

Please check each symptom you currently have or leave blank if N/A.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Gen** |  | **Shen** |  | **PI** |  |
| Irritability / frustration / impatient |  | Frequent urination |  | Heaviness in the head / body |  |
| Depression / Stress |  | Bladder infection |  | Fatigue / after eating |  |
| Emotional eating |  | Lack of Bladder control |  | Difficult getting up in morning |  |
| Unfulfilled desires |  | Wake to urinate |  | Water retention |  |
| Visual problems / floaters |  | Feel cold easily |  | Muscular tiredness / weakness |  |
| Blurred vision / poor night vision |  | Cold hands / feet |  | Bruise easily |  |
| Red / Dry / Itchy eyes |  | Low sex drive |  | Unusual bleeding (stool, nose, etc) |  |
| Headaches / Migraines |  | High sex drive |  | Bad breath |  |
| Dizziness |  | Hair loss |  | Poor appetite |  |
| Feeling of lump in throat |  | Hearing problems |  | Increased appetite |  |
| Muscle twitching / Spasm |  | Crave salty food |  | Crave sweets |  |
| Neck / Shoulder tension |  | Fear |  | Poor digestion |  |
| Brittle nails |  | Poor long term memory |  | Nausea / vomiting |  |
| Sighing |  | Ankle swelling |  | Bloating / gas |  |
| Sensation of pain under rib cage |  | Tinnitus (High/low/constant) |  | Hemorrhoids |  |
| PMS |  |  |  | Loose stools |  |
| Genital itching / pain / lesions |  | **Fei** |  | Alternate constipation / loose |  |
| **Xi** |  | Dry cough |  | Abdominal pain |  |
| Palpitations |  | Cough with Phlegm |  | Intestinal pain / cramping |  |
| Chest pain / tightness |  | Nasal discharge / drip |  | Heartburn |  |
| Insomnia / Sleep problems |  | Sinus infection / congestion |  | Pensive / over-thinking |  |
| Restless / easily agitated |  | Itchy / painful throat |  | Overweight |  |
| Vivid dreams |  | Dry mouth / throat / nose |  | Foggy mind |  |
| Lack of joy in life |  | Skin rashes / hives |  | Yeast infection |  |
| Forgetful |  | Snoring |  | Aversion to cold |  |
| Aversion to heat |  | Grief / sadness |  | Cold nose |  |
| Bitter taste in mouth |  | Shortness of breath |  | Increased thirst |  |
| Tongue / mouth ulcers / cankers |  | Allergies / Asthma |  | Prefer Warm / Cold drinks |  |
|  |  | Weak immune system |  | Do you easily sweat? |  |
| Alternate fever / chills |  |  | |