

|  |  |
| --- | --- |
|  | 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: |

|  |
| --- |
| 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 |

|  |
| --- |
| 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* |  |

|  |
| --- |
| 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 |  |  |