Vikki Harrison-Edwards PGDip Bsc (Hons) MBAcC
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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:	

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

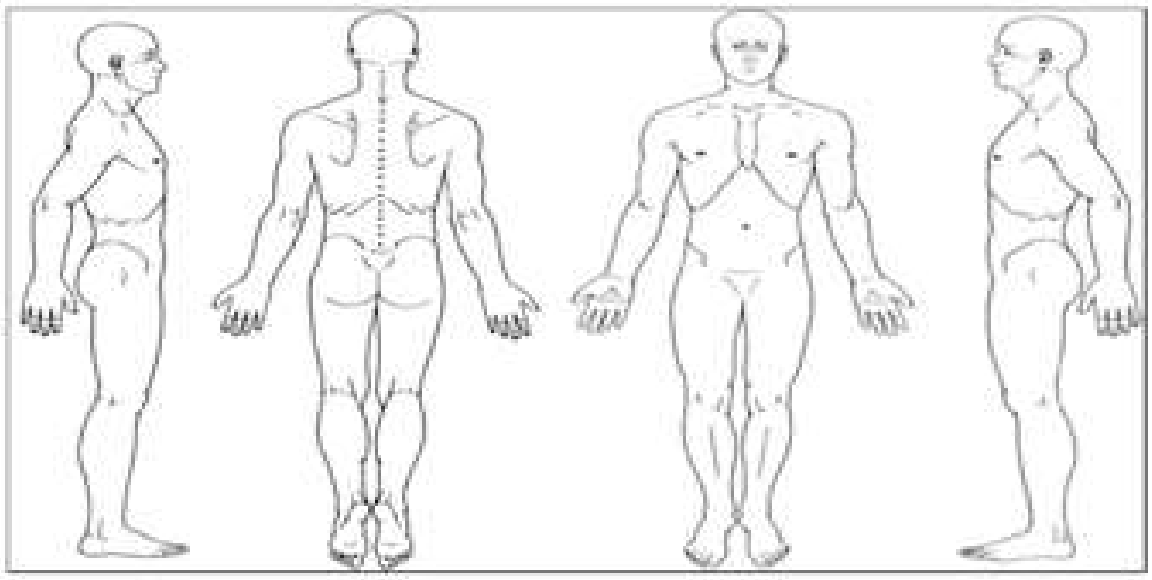
Weekly exercise

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			

Patient consent form